Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2 Date of Death 3. Time of Death 8:00 A M Physician/ 2012 anuary Medical r Location of Death 4c. County of Death **Examiner** lerrac timore 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours Min. (Month, Day, 1 ■M 2 □ F 86 **Director** -10-1925 10d. Inside City Limits 10c. City, Town or Location with the Maryland Completed by Funeral Director Hore notified 28a-f 1 Yes 2 No 5 10g. Citizen of What Country? ms 23a or must be lerrace USA oplar 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian Black, White, etc. item 27 is marked other than "natural", or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Worker College (1-4 or 5+) To Be Father's Name (First, Middle, asionship (Type, rint) Daugh Department of Health Important: If item 2: any injury or other tonce. Rlace of Disposition (Name of d of Disposition ■ Burial 2 ☐ Cremation 3 Removal from State Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -e disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my rewriting, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 5. Greene D 21201 m 32. Re Registrar

DHMH 17 Rev 06-2011

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Funeral Director		5. Social Security Number 217–28–1009 Usual Residence of Decedent	6. Sex 1 \(\text{M} \) 2 \(\text{XF} \)	e (In yrs. last birth		If Under 1 Ye Months Da	ear ays	If Under 24 Hrs Hours Min		ay, Year	9. Birthplace (State or Foreign Country) 1918 Maryland		
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	6	Marital Status Never Married 2 ☐ Marrie Midowed 4 ☐ Divorced	Ever in U.S.						<u> </u>	14. Race - American Indian, Black, White, etc. Specify: White			
Baltimore, Maryland 21215-0036 sernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene. mportant: If item 27 is marked other than "natural", o my injury or other traumatic event, the Medical Exami nose. To Be Completed by	III piete	15. Decedent (Specify only highest Elementary/Seconday (0-12)			Decede (Give kir	nt's Usual Oc	cupa		rking	16b.	Kind of Busines		
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Limore Page 1 street of the tant: If its jury or of	2	0a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 4 □ Donation 5 □ Other (Sp	Removal from State	20b. Place of cemeters Ardent	crema Cr	ematio	place n	2/1	Date /2012	F	Location - City of Hanover ,	MD	
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To with	2	9b. Signature and title of certifier	MD			29c. Lice		79 <i>5</i>			ate signed (Mon $2/31/2$		ar)
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State Registrar	3	FEB 0 1 2012 (ear)		r's Signature					<u></u>			-	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Physician/ reet and number) 4a. Facility Name (if not institution, give st Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Rundalists If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Davs (Month, Day, Year) Country) Director or 28a-f show notified at 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Xes 2 No Sor MER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or dical Examiner must be n Funeral 2124 within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married þ Ves Baltimore, Maryland 21215-0036 1 Yes 2 And Specify: Year or Dates. ARMV 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier is marked other i Be 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 1995 permit. Page 1 and 2 should | Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 340 Important: If item 27 i any injury or other tra enise 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State FOLES WINGS 4 Donation 5 Other (Specify) any in once. 21. Signature of Funeral Service L 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) O pr as a consequence of Medical Examiner moh Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Dut to (or as a consequence of attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after dental.

To the Funeral Director After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

31. Date fileð (Month, Day,

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 2 1 - State Registrar Certificate of Death Reg. No 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TANUARY 2012 :20A BEATRICE DECOSTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 1 □ M 2 🔀 F July 10, 1926 Massachusetts 032-18-1706 85 28a-f show 10b. Count 10a. State 10c. City, Town or Location 10d, Inside City Limits event, the Medical Examiner must be notified at Director MD Frederick Frederick 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 23a USA 1705 Aldin Court 21701 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force 1 Never Married 2 Married þ Yes 2X No P Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: "natural" White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Pavao Medeiros Antone Rego permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Aldin Court Frederick, MD 21701 Russell J. DeCosta/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 01/31/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ging Home Cremation Service Beverly L. Heckrotte, P.A. C. ce P.O. Box 784 Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ SOLE disease or condition Medical resulting in death) Examiner Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed neumoni and -tran Due to (or as a consequence of) resulting in death) Last burialphysician s the buria Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) Pregnant at time of death Unknown g Unknown Records, P.O. signed by tall to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed?

Yes 2 No this certificate 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital Other: 2 100 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Impatient 2 27. Mann Death Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After (Month, Day, Year) injury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Fractitionar To the best of my knowledge, Seath one. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1.29.2012 D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 Johnson DV. Hemen Shah 65 Thomas. 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DAVIS Physician/ JAMES DI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Harwood Anne Arundel 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday If Unde 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) March 1, 1926 Hours Min. Director 212-20-1031 1**X** M 2 □ F 85 Maryland Yrs show 10b. County 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Prince Georges Hyattsville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5805 42nd ave; Apt 315 20781 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No 1944- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: white "natural", 3 X Widowed 4 ☐ Divorced 1944 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) home improvement painter event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margie Marie Dugaree Page 1 and 2 should be Roland James Davis of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14732 Warfordsburg Rd; Hancock, MD 21750 Jean Bishop - niece 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or oth 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Name and Address of Facility State Analomy Board Ronal 655 W. Baltimore St; Baltimore, MD 21201 Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final DISEASE OBSTRUCTIVE I'UL MONARY Physician HRONIC disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine riany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 the IF FEMALE ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown q Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h Yes 2 completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 ₺ No MANDARIN မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-24-12 D 14774 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SiJAHID AZIZ H.D. 445 DEF

Registrar

State

31. Date filed (Month

AZIZ

32. Registrar's Signature

DEFENSE

HNY

ANNAPOLIS

MD 214-01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02506 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 RODRIGUE **EDMOND** JANUARY 9:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ST. THOMAS MORE NURSING HOME HYATTSVILLE PRINCE GEORGE'S 6. Sex 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐M 2 ☐ F Hours Months Days Min (Month, Day, Yea Country) HAIT1 Director 578-86-9020 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6701 VERMONT COURT 20785 HAITI 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify. BLACK 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th CAB DRIVER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည ROGER EDMOND ANDREA MOREL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trat once. MYRTHA EDMOND/SISTER 6701 VERMONT COURT HYATTSVILLE, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLENWOOD CEMETERY 2/4/2012 WASHINGTON, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Naphney 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Let the distese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Artemoschero Onset and Death Physician/ disease or condition resulting in death) YEAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or). signed by the attending physician and I be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cevebral Infarction Encepholopathy Dysphasia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown has been Chrome Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after death To the Funeral Director: completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01852 VANUARY 24 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

State Registrar DEVORE MD 4203 QUEENS BURY RI HYATK VINE MD 20781

ay, Year) 32. Registrar's Signature

31. Date filed (Month, Day, Year)

See 1 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 9:40 P^{M} January Howard William Everetts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hardord Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25, 1955 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** Maryland 218-64-4306 1 X M 2 □ F 56 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Whiteford Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11557 Main St; Apt 8 21160 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Snorkel Economy forklift operator n and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even any injury or other traumatic even once. Vera Keller မ Howard William Everetts Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Marie Everetts – daugh**t**er 230 Mayberry Dr #303; Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Xother (Specify) in state 21. Signature of Euneral Service Licensee, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Curcinoma disease or condition resulting in death) Squamma Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any hading to him recipitate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Vital Records. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/23/2012 MO D0064015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evonne Donelson BUL Air MO 21014 Drivi State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Januar BEATRICE **EAMES** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Baltinor Hosp/tal Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth Social Security Number . Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. 1 M 2 X Months Hours (Month, Day, Year) 07-03-1913 213-36-287 Director 98 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location must be notified at with the Maryland Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number items 23a Funeral 3021 WALBROOK AVE. 21216 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes No Black, White, etc. . or 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: BLACK "natural", 3X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWORK Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ROBERT KESSLER FRANCES PRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDWARD U. EAMES/SON 5308 ST. GEORGES AVE. BALTO. MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ō **=** ₀ 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or **BALTIMORE CEMETERY** 2/02/2012 BALTIMORE, MD 22. Name and Address of FaciliTAMES A. MORTON & SONS F.H. INC Signature of Funeral Service Licensee mesci 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Undanying Cause (Disease or iinjury law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as attending IF FEMALE f yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) t 12 months? in the past 12 for Month Pregnant at time of death 1 Yes 2 been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death?

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h W AMES,

certificate has funeral director, page 2 the Funeral Directory filled in by the

Be

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Certificate:

Medical

Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

28c. Injury at

work?

26. Place of Death (Check only one)

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify,

28d. Describe how injury occurred

8:45

W. VA

10d. Inside City Limits

Approximate
Interval Between
Onset and Death

Year

2012

Day

2 🗌 No

1 Tes

1 X Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of cer N/1:1356659031

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

900 Caton Ave. Baltimore, MD 21229

State Registrar

25. Was case referred to medical

examiner?

1 Yes 2 No

27. Manner of Death

1 🕱 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA

28b. Time of

within 24 ho

To the Fune

completed f

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JANUARY 30 2012 ROBERT G. FITZGERALD 3:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE HOWARD COLUMBIA If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days NOV. 27 Hours Min 1975 **Director** 219-15-1105 1 XM 2 □ F 36 WASHINGTON, DC 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 1 X Yes 2 No MD PRINCE GEORGE'S LAUREL ms 23a or must be n 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13042 OLD STAGE COACH ROAD #212 20708 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ö ģ 1 XNever Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the PRIVATE SUPPORT SPECALIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic even မ ANN JACKSON HAILE FITZGERALD JR. PEGGY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health : 13042 OLD STAGE COACH ROAD #212 LAUREL, MARYLAND PEGGY ANN FITZGERALD/MOTHER 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 2/4/2012 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 23a. Part 1. Erker the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ NEUROFIBROMATOSIS TYPE DECADES disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and I for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director; After this certificate has been signed by the attending physicia IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an is certificate has to director, page 2 s autopsy performed? 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home 5 🔲 Residence 6 🔀 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760 Records,

Division of Vital

within 2 To the F

Registrar

Medical

29a. Certifier

only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

D64395

29d. Date signed (Month, Day, Year)

JANUARY 30,2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

CLOAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMANIMO 6336

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 2012

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32. Registrar's Signatur Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 25, 2012ª Physician/ Almond George Ford, Jr. 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 7, 1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Texas Director 1 🛛 M 2 🗆 F 037-12-0189 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland Director notified 28a-f 1 Yes 2 X No MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ms 23a or Funeral USA 20814 108 Lucas Lane death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status th and Mental Hygiene. 27 is marked other than "natural", or itel traumatic event, the Medical Examiner Armed Forces?

1 X Yes 2 No Black. White, etc 1 Never Married 2 Married Yes Give þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Year or Dates 1950-51 Completed 3 XWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) County School System 4 Bus Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dorothy Jean Pettus George Almond Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21795 Department of Health ar Important: If item 27 is any injury or other traconce. 16505 Virginia Ave. Cottage 192 Williamsport, MD Ann C. Ford/sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Place of Disposition (Name of Date 20c. Location - City or Tox Cemetery, crematory or other place)

Final Journey Crematory 01/28/12 Woodbine, MD 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Goling Montes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. <u>MO1251</u> 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical for use as the k 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia, TIA, Prostate Cancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) hospice ဂ္ 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 🛚 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855 Date filed (Month, Day, Year)

FEB 0 1 2012 Registrar

32. Registrar's Signature S. Jake 29c. License number

R143201

29d. Date signed (Month, Day, Year)

1.26.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:00 P. M Clifford Ferrin, Sr. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore 349 Grove Park Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 220 14 8639 Director 1 🛛 M 2 🗆 F 86 01/13/1926 Yrs Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a, State must be notified at Director 1 Yes 2 XNo Baltimore Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or 23a Funeral U.S. 21225 349 Grove Park Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items death 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give Year or Dates. "natural", II Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) 12th College (1-4 or 5+) Oil Refinery Laborer other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles Edward Ferrin Lillian Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Ferrin / Wife 349 Grove Park Road Baltimore, Maryland 21225 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department of 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State = 6 01/26/2012 Important: It any injury or Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter the disease, shock, or heart failure. List only Immediate Cause (Final Pnysician/ vear disease or condition resulting in death) Medical Examiner VearS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for 1 Month Day 5 Other (specify) Pregnant at time of death detached 9 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe e 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 266 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No of Funeral Director: As bletely filled in by the funeral price to the filled in by the funeral f Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

completed only one 29b. Signature and title of certifier 2/225 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2

1 - State Amend Item 10e per fh, g924,02/09/2012dhb
Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2

Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12561 Doris M. Gambrill TANUAR 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CIEN BURNIE AHNE BRUNISE DACTIMORE WASHINGTON MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 TxF Months Year) **Director** 215-40-3277 MD Aug 30, 1938 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Funeral Director be notified 1 Yes 2 No **Baltimore** MD **Anne Arundel** ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a o 453 Crucible Court 21108 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Black, White, etc. 0 by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Teachers Asst. **Baltimore City Schools** other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 . Page 1 and 2 should be funent of Health and Ments Ruth M. Allen Nathaniel Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,u 27 Millersville, MD 21108 Joyce Gambrill 753 Crucible Court, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of H 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Halls United Methodist Church Jan 27, 2012 Glen Burnie, Maryland Signature of Porral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death MEUMONIA Physician/ Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Examiner sequence of ANULOMATOUS LUNG DISEASE Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Pending 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 2012 len Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MBRILL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GOINES Physician/ JAN. 12:22 AM MAE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRONTRICK GOLDEN LIVING CENTER FREDERICK If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** 579-48-5075 Director 1 🗆 M 2 🎜 F 1932 WASHING TON DIC or 28a-f show 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director mo. FREDERICK FREDERICK 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a DR. WAVERLEY 00102 USA 21702 or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 ☐ Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) HOTEL College (1-4 or 5+) HOUSE KEEDING 8 11+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HENRY L. GOINES LUTTIE STINNET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAVERLEY DrIVEDD 102 FREDERICA MO (DAU) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4,20,2 MT. ROJAR MO. FORTLINGULUCEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 6 ARYL . ROLLINS PUNCHAL ITOM E permit. 21. Signature of Funeral Service Licensee rung x-FREDERICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final HONIC Ph_sician/ MUMORINU TRUCTIVE disease or condition Medical resulting in death) **Examiner** EMENTIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No
9 Unknown detached for Month Year g 🗌 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law in 24 hours after death.
 Funeral Director: After this certificate has to be a continued on the continued of t autopsy perform death? 1 ☐ Yes 2 🔀 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) un 4795 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

113-TF A KAZMI, MD XIY TOLL HOUSE AVE. FREDERICK

Registrar

State

Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 8-55 PM Physician/ Day 30 Gleason 2012 Michael J. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5708 Namakagan Rd. Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 485-16-2595 Mar 28, 1**X** M 2 □ F 85 **Director** 1926 Iowa Usual Residence of Decedent show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD Bethesda 1 Yes 2X No Montgomery 10e. Street and Number 10f. Zip Code OF 10g. Citizen of What Country? r must be r Funeral 5708 Namakagan Road 20816 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ed Forces? Yes 2 No the Medical Examiner Black, White, etc. ō by 1 Never Married 2X Married 1X Yes Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates. 1944–46 Specify: White "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Broker Insurance event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ဂ James Gleason Mary Alberts Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gleason/wife 5708 Namakagan Road Bethesda, MD 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 02/01/12 Woodbine, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Cardiomyopath Ischemic Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 20 years oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) ding physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year, 32. Registrar's Signature

Colliver

FEB Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wirainia Calliver 10410 Rockledge Dr Suite 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 1:00 AM Evelyn Elise Grace January 22 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | **Funeral** 214-30-7124 1 □ M 2 🖾 F Days Director Yrs. Sept 8, 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits the Medical Examiner must be notified at MD Harford Director Bel Air 1 ☐ Yes 2 X No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 300 Sun Flower Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 🛛 No white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer factory is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental Albert Norris Bosley Mary Virginia Sweeting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trains Donna Poole - daughter 1114 Vanguard Way Apt F; Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death eart failure. List only Immediate Cause (Final disease or condition resulting in death) Bran **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 2 No 5 Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Junknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 ☐ Yes 2 No 1 Tyes Be 25. Was case referred to nedical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 6 of person who completed cause of death (Item 23a) (Type, Pr

Registrar

State

31. Date filed //

EVELYN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Pate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** n/a Baltimore 220 Wendover Road 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 064-52-7585 **Director** 1 □ M 2**X** F Dec 18, 1952 Norway 59 Yrs or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Baltimore 1 X Yes 2 No MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Norway 21218 220 Wendover Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes Give 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Zen Teacher 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Braekhus Magdalene Biong Henrik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven R. Gambert, M.D.-husband 220 Wendover Rd., Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Towson, MD 2/2/12 Hilltop Serv Corp 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service icensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying
Cause (Disease or injury Due to (or se a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-trar and that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ☐ Ectopic pregnancy ☐ Other (specify) ___ Month Day Year Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 Yes 2 No After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural Accident iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29c. License number Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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erson who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 29, 2012 Physician/ 7:45 am **JEAN** HUNT BARBARA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A BALTIMORE FUTURECARE COLDSPRING If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours JAN 1th, Day, 4ear) 1948 Months Days Min 1 □ M 2 😾 F MARYLAND 219-50-2385 64 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 XYes 2 No MD N/ABALTIMORE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 600 ARSAN AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 2 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE "natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) MEDICAL PHYSICAL THERAPIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ည RUBY LORRAINE FRAZLER EVERETT EARL ELMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i 6733 MALLARD ROAD, MIDDLE RIVER, MD 21220 CHARLENE SPILKER/NIECE Important: If item 2 any injury or other once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State BAYVIEW CREMATORY 1/31/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Sprvice Licensee 22. Name and Address of Eacilty ER INC FUNERAL HOME T901 EASTERN AVENUE, BALTO., MD robert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCND Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ause (Disease or Initially burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Hospital or Attending Physician: The law requires that the death certificate be Box 68760

by Physician/Medical Completed cate has page 2 s Be ithin 24 hours after death.

the Funeral Director: A pumpleted filled in by the fu

P.O.

Records,

Division of Vital

IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Other (specify) Pregnant at time of death 1 Yes 2 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No __ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) icense number Dou 69314

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Re Powerdle MD 21234

State Registrar

within 2 To the F

31. Date filed (Monta)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittel Projepat: 8813 Waltham Woods

strar's Signature

epat.

1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 02518 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:15 p ^M HOWARD January 2012 KENNETH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 3824 OFFUTT RD. RANDALLSTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8 Date of Birth **Funeral** Days (Month, Day, Year) **Director** 214-26-8662 1 🕅 M 2 □ F 82 Yrs. MAR. 13 1929 MARYLAND Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho 7 is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2X No BALTIMORE · MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3824 OFFUTT RD. 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 X Never Married 2 Married 2 X No þ Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify:WHTTE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade COURIER MAIL SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM T. HOWARD other traumatic LILLIAN HOFNAGLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is range injury or other any or other any injury or other any o 3824 Offutt Rd., Randallstown, Md., 21133 Henry W. Mosley/Campanion 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) OAKLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 02-01-12 BALTIMORE, MARYLAND 21. Signa of Funeral Service License 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death sease Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Due to (o **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No Yes 1 ☐ Yes 2 L 9 ☐ Unknown the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? certificate Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title, 29d. Date signed (Month, Day, Year)

State Registrar Eastern

of person who completed cause of death (Item 23a) (Type, Print)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)		00111	noute or E	- Cuti i	1 0 D.t (D.	Reg. No. 🔼 🔱	Venu	3. Time of Death
	Physicia Medic		James B H	ovale	Ý			Month N		JC17	1215 AM
	Examin	er	4a. Facility Name (if not institution, give street and Bultimere weshing to	number)	- 4	46. City, Town, or	Location of Death	1	4c. County Avve	1.6	laku
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h		ace (State or Foreign
	Director		214 48 0661 1 M 2 Usual Residence of Decedent	F 64	Yrs.			12/29	71947		y Virginia
	land f show d at	tor	10a. State 10b. County		Town or Loca					10	Od. Inside City Limits
	e Mary r 28a-	Direc	Maryland Anne Aruno 10e. Street and Number	lel .	Pasader	10f. Zip Code			10g. Citizen of	What Count	1 Yes 2 No
	with th	Funeral Director	8426 Miramar Road Ap	t. 10			21122		U.S		.,,.
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 X	Decedent Ever in U.S. d Forces? /es 2 \(\subseteq \text{No}\) Give or Dates.		spanic Origin? (Sp n, Mexican, Puerto Specify:		Bla	14. Race - American Indian, Black, White, etc. Specify: White		
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Maryland	should be file n and Mental I 7 is marked o raumatic eve	<u>1</u>	Burke Mc 19a, Informant's Name/Relationship (Type, Print)	Coy Honake		ille Mil		State Zin C	ada)		
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Baltimore,	e 1 and of Heal If item 3		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal		ace of Disposit metery, crema	tion (Name of tory or other place		Date	20c. Location	- City or To	wn, State
Ħ.	permit. Page Department of Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Specify)			rematory		04/2012			Maryalnd
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			23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of	hat caused the death. in each line.	Do not enter	the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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J Jc	y Phys er this eral dir	e: 10	27. Manner of Death 28a. I		28b. Time of	3 □ DOA 28c. Injur	4 <u> </u>	Home 5 Resi 28d. Describe I	dence 6 🗌 Oth now injury occur		
ono	ending sath. or: Afte he fune	ficat	2 Accident Investigation	Month, Day, Year)	injury	M 1 □	<br Yes 2 ☐ No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Il Certificate:		Place of Injury - At hon building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (City or Tox	Street and Numb vn, State)	per or Rural	Route Number,
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	To the Hospital within 24 hours a To the Funeral completed filled	Σ	only one) 3 Certifying Nurse Practio 29b. Signature and title of certifier	ner: 10 the best of my	knowleage, de	29c. Licens		ace, and due to th	29d. Date signe		
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اس اس	. /		30. Name and address of person who completed	cause of death (Item	23a) (Type, Pri		d Fl.	R IL		MI	21201
1	Sta	te	31. Date filed (Month, Day, Year)	32. Regionar's Signa	A CONTRACTOR OF THE PARTY OF TH	weer of	111	DUTTIV	uere,	75-70	010-1
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 1:00 A M Physician/ January 31 2012 Hickey Geraldine M. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Lutherville 103 Road Baltimore Ardoon 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** 218-26-3108 80 **Director** 1 M 2 X F October 5 193¼ Pennsylvania 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
if them 27 is marked other than "hatural", or items 23a or 28a-f show other trannatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County Director 1 🗌 Yes 2 🔀 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 103 Ardoon Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 9 Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unit Clerk St. Josephs Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madeline Cooper Quentin McDonald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 14 Gregoria Court, Baltimore, maryland Brian Hickey / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/1/2012 Towson, Maryland HilltopServiceCorp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundament Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Months meta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 999 COPD Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 morths?

1 Yes 2 No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 8c. Injury at injury work? Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

State Registrar

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Registrar FEB 0 1 201

BRIJEN

31. Date filed (Month, Day, Year)

MD SINTH HOSPITAL OF BALTIMORE 2401 W Belvedon Av. MD 2125

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MZOL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #17 Per ANA BD G9321 10/11/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 7:35 PM M January Chester Joseph Jacynski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Essex 184 Bennett Road Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Davs Hours Min (Month, Day, Year) 220-03-6712 **Director** 1 X M 2 🗆 F Pennsylvania Usual Residence of Deceden 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 85 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. <u>\$</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) plumber plumbing Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Paczynski Sophia Chludzinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 185 Bennett Road; Essex, MD 21221 Elizabeth B. Jacynski - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 ☐ Other (Specify) Sign ture of Fureral Service Licens (On a Ld) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 nos Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

rediate Cause (Final ase or condition

FudStace Heart Disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No detached for Month Day Pregnant at time of death 1 Yes 2 Lg Unknown q Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pe 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy death?
1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 5 Residence 6 Other (Specify, ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and/or inventioning in any control of the cause of examination and control of examination and 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year)

Registrar

State

arrison MD 6095 Marshalee Dr. ElKridge, MD21075

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chewles M. H.
31. Date filed (Month, Day, Year,

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:30 a^M JESSIE VIOLA 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12209 EASTERN AVENUE CHASE BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Days Hours Country **Director** 216-16-5209 1 M 2 XF Yrs 87 DEC. 14 1924 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland or items 23a or 28a-f sho miner must be notified at Director 1 Yes 2XXNo MARYLAND BALTIMORE CO CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12209 EASTERN AVENUE 21220 U.S.A. death \ "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DAY CARE PROVIDER CHILD CARE 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or cat. nd Mental F JAMES S. SMITH VIOLA ROY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte M. Breeden/Daughter 12209 Eastern Ave., Chase, Md., 21220 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XXSurial 2 Cremation 3 Removal from State HOLLY HILLS MEMORIAL: 02-04-12 MIDDLE RIVER, MARYLAND 4 Donation 5 D Other (Specify) Signature of F WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILA. BLVD., ABERDEEN, MD 21001 complications that caused the pleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to pr as a consequence of) Examiner SVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delive 3 Ectopic in the past 12 months?

1 Yes 2 No for Pregnant at time of death Other (s signed by the a 9 Unknown 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 25. Was case referred / medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at work? __1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) 3 0 of person who completed cause of death (Item 23a) (Type, Print), 107 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c &23taRe of Mar 9924 /2/098/1298/1298 and Mental Hygiene 20 | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 26 Physician/ 201^{Year} 7:40 Steven Kemper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days March 10, 1954 1 💢 M 2 🗆 F Washington, DC Director 57 579-76-8365 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Washington 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 USA 4423 Gult Place NE; Apt 4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction Burton & Robinson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Verdell Elizabeth Washington Samuel William Kemper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Myrtle Ave; Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type, Print) Laverne Kemper - sister 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Heritage Cemetery 2/11/2012 Waldorf,MD 4 Donation 5 Other (Specify) . Signatur of Funeral S rvice Licensee Capteol Mortuaby State Ronald S. Wade Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** mmuhodeficena Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director, After this certificate has been signed by the attending physician and mipleed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Ne 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗆 Yes 2 🖵 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 LING 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖵 🗲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUVD niversy Mymins ic 31. Date filed (Month) Day, 32. Registrar's Signature State acke Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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6 2 E 12 13		Du	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												MD 21029
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Certificate:	4 Homicide	determ	ined 28e. Place o	f Injury - At I g, etc. <i>(Speci</i>		, street, fact	ory, office			28f. Location (City or To			er or Rural	Route Number,
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01		30. Name and addr Joel Ka/li	man, M.	who completed cause D. 1396 Pi	of death (Ite	m 23a) (Typ Driv e	e, Print) e Rocl	<ville< th=""><th>e, MD</th><th>208</th><th>50</th><th></th><th></th><th></th><th></th></ville<>	e, MD	208	50				
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1 Yes 24 No Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: White If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical School/ should be filed with and Mental Hygien. Lab Technician Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Kuhn Doris Casola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5329 Saratoga Avenue Chevy Chase, MD 20815 Dennis McKearin/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 01/31/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature Funeral Service License Sing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ances years UGNER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate
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5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown the s Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

1650

Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 1 2012

mstrung

36986

Orleans St. Rm 190.

			For State Registrar	State of Ma	iryland /			of He			giene Reg. No.		
	Physicia		Decedent's Name (First, Middle, L	.ast)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, g	ng			4h City 1	Town or Lo	ocation of Death		2 Q	2012 County of Death	
	Examin	er	C . C	Westing	O In	t.			rello Nec		torer	500	rerset
Ī	Funeral Director		00001-111		(In yrs. last i	birthday) Yrs.	If Under Months		Under 24 Hrs. Hours Min.	8. Date of Bir	th	Cou	place (State or Foreign Intry) IIS iana
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits
	Maryli -f sho	to		rset	Wes	stove	r						1 ☐ Yes 2 🔀 No
	h the	Director	10e. Street and Number				10f. Zip				-	en of What Cou	intry?
	ath wil		30420 Revells					890	0 1-1-0 /0			SA 4. Race - Amer	ican Indian
036	d within 72 hours after death with the Maryland speed. Then "naturel", or Itams 23a or 28a-f show the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 □ Yes 2 № N If Yes, Give Year or Dates:	Armed Forces? If Yes, specify Cuban, 1 ☐ Yes 2 Ø No If Yes, Give 1 ☐ Yes 2 Ø No				Mexican, Puert Specify:	o Rican, etc.)	Black, White	, etc.	
215-0036	72 ho	eted	15. Decedent's (Specify only highest of		16	6a. Deced	ent's Usua kind of wor	l Occupation	on unk ring most of wor	rking	16b. Kir	d of Business/I	ndustry unk
121	within noe. Ihan "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	ilfe. D	OO NOT us	e retired)					
g 5	filed Hygi ther ant,		unk 17. Father's Name (First, Middle, La	unk st) unk				1:	8. Mother's Nar	ne (First, Middle	, Maiden .	Sumame) un	k
an	B E B	To Be											
Maryland 21	E 5 2 2		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailin	g Address	(Street and	d Number or Ru	ıral Route Numb	er, City or	Town, State, Z	ip Code)
	s 1 and 2 f Heatth Itam 27 othar tra		Captain Paul B	lake	20b. Place				ls Neck	Rd; Wes		ation - City or	
Baltimore,	permit. Pages 1 Department of H Important: If Ita any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☑ Other (Spe	city) in state	ceme	atery, crem	atory or o	ther place)					, own, orac
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice Ronald S		ector	22.				ate Ana St; Ba			21201
			23a. Part. Enter the disease, or co	omplications that caused	the death. D	o not ente							Approximate Interval Between
	Physician /Medical		23a. Pan. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it was failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										Onset and Death
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	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	a consequen	ce of):						-	
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687		edicai		0.							-		
.O. Box	at the death certific by the attending p tached for use as it	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	Ectopic pr Other (sp		2	3d. Date of deli Month	very Day Year				
rds, P.	quires that t n signed by ald be detac	d by Physi	1 Vos 2 No 3 Probably										the cause of death?
l Records,	the Hospital or Attanding Physician: The law requires that the inin 24 hours after death. The father death tha Funaral Director: After this certificate has been signed by the principle of the funeral director, page 2 should be detached the father than th	Completed							· · · · · · · · · · · · · · · · · · ·	24a. Wa: auto peri 1 🗆 Yes		death?	stopsy findings available completion of cause of 2 \sum No
<u>Zita</u>	clan: sertific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Other		ath (Check only		,	0:
of	Phys r this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ry 28	Outpation b. Time of		28c. Injury a Work?		Home 5 ☐ Res			city) rusin
on	nding f tth. : After e funer.	ation	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y Year)	Injury	М		es 2 □No				
Division of Vital	al or Attandi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could no determin	ad 200. Flace Ut 111	8 290 Place of Injury At home farm street factory office 28f Location (St								ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best caminer: On the basis o and manner sta	f examination	dge, death and/or inv	occurred vestigation	at the time , in my opin	, date and place nion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
,	To th within To th compl	Me	29b. Signature and title of certifier	1		,	290	c. License			29d. Dat	e signed (Mont	h, Day, Year)
				Lm	>			DO	05870)		- 1	26/12	
			Jason Clem		FOIN	(ox	rec	-tcon	الم الم	INS+	We	istover	MD
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 1 20	12 Server	ar's Signature	face	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29, 2012 5:22 p M January Betty Kreuzbura Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death The Maples Baltimore Towson 5. Social Security Numbe If Under 1 Year If Under g. Birthplace (State or Foreign . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 DY Davs Hours Months (Month Washington, D.C 577-01-3548 93 **Director** 1918 Aug Usual Residence of Decedent "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 7925 York Road 21204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan (Not known) Weigle Imogene Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Rommel-daughter P.O. Box 757, Riderwood, MD 21204 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Serv Corp 2/1/12 Towson, MD 21. Signature of Funeral Server Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 6 Physician. 10 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spe 2 1 No Assisted L မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Acilit Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No ☐ Accident ☐ Suicide within 24 hours after death

To the Funeral Director: A

completed filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

ditle of ertifier

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:15 AM KESTNBAUM JANUARY 2012 MARCIA 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **BETHESDA** MONTGOMERY SUBURBAN HOSPITAL If Under Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Hours Min (Month, Day, Year) 154-30-7915 1 □ M 2 🗓 F Yrs. 72 12/02/1939 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No MD NORTH BETHESDA MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 TUCKERMAN LANE 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 X Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, SIGMUND DYCKMAN RUTH WEINSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT KESTNBAUM/EX-HUSBAND STEPPING STONE LANE, GREENWICH, CT Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State TOWNSHIP OF WASHINGTON, Date 1 X Burial 2 ☐ Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 01/29/2012 | BERGEN COUNTY, NJ 21. Signature of Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 0 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): 23d. Date of delivery Month Day Year o use contribute to the cause of death? 2 🗓 No 3 🗆 Probably 4 🗆 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

ce, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

20814

01/29/2012

Ph_sician/) Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

ms 23a or must be with 1

"natural", or iten edical Examiner r

Hygiene. other than ' ent, the Me

1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other thother traumatic event, the

Department of Healtl Important: If item 2: any injury or other t

Director

Funeral

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Completed

Be

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the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

1

160 68760 C

Marria P.O.

Kestnbaum,

Box

Récords,

Division of

or Attending Physician: The law requires

Hospital

To the within 2 To the I Complet

29b. Signature and title of certifier

AVA KAUFMAN,

31. Date filled (Month, Day, Year) FEB 0 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

M.D.

24 hours after deat Funeral Director:

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) g Unknown	23d. Date of delivery Month Day Yea		
Completed by P	Part II. Other significant conditions of MULTIPLE SCLE	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Un 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings ave prior to completion of cau death? 1 ☐ Yes 2 ☐ No		
Be (25. Was case referred to medical	26. Place of Death (Check	only one)		
일	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other; 4 □ Nursing Hole	me 5 Residence 6 Other (Specify)		
Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigatio	(<i>Month, Day, Year</i>) injury work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical	(Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, an iner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practitioner : To the best of my knowledge, death occurred at the time, date and pla	the time, date and place, and due to the cause(s) and mann		

Registrar DHMH 17 Rev 06-2011

State

8218 WISCONSIN AVENUE, BETHESDA, MD

29c. License number

D26259

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Timothy Edward Les	ster State of Maryland / Department o	f Health and Mental Hy	rgiene 201	2 0253						
	1- For State Certificate O Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 2. Date of Death	3. Time of Death						
Physician/ Medical Examiner			Month Day Year January 30, 2012	0320 hrs						
(4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Aberdeen	4c. County of Deal Harford	h						
	624 Oak Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. B	rthplace (State or						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219 60 8538 1 M 2 F	Months Days Hours Min.	June 26,1955 Fore	gn ountry) Germany						
	Usual Residence of Decedent			Links in On time						
yas y	10a. State 10b. County 10c. City, Town or Local Maryland Harford Aberdee			10d. Inside City Limits 1 Yes 2 No						
fland fland once.	7.44.7.44.14	10f. Zip Code	10g. Citizen of What Co							
t or 28a-f sh ifficed at onc Director	10e. Street and Number 624 Oak Court	21001	USA							
	11. (1)	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Ame White, etc.	rican Indian, Black,						
r death with or items 23 must be no	Never Married 2 Married 1 Yes 2 X No	Yes 2 X No specify:	Specify: Bla	ack						
rs after rral", miner	0	Yes 2 1 No specify. Int's Usual Occupation (Give kind of w								
5-0036 ed within 72 hour 9/9 giene. other than "natu the Medical Exau Completed	College (14 or 5+)	nost of working life. DO NOT use retinate Giver	Health (Care						
vithin ene.	12		(First, Middle, Maiden Surname)							
215-0036 be filed within 72 hours after that Hygiene. riced other than "natural", ent, the Medical Examine Be Completed by	17. Father's Name (First, Middle, Last) David Lester	Dolores								
212 ould be d Ments s mark tic even	100.1110.11	ng Address (Street and Number or F	Rural Route Number, City or Town, Sta							
MD 2 d 2 shoul lith and M n 27 is m TG	Virginia Lester (Wife) 1519	Ridge Rd. Whitefosition (Name of cemetery,	ord, Maryland 211	or Town, State						
nore, ages l an nt of Hea nt: If iter other tr	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition 1 Removal from State									
time trest trest rest		Name and Address of Facility ruzdzinski Funera								
Balt permit. Departi Import injury	Lake W Kurkausko	107 Old Factorn A	venue Essex. Marv	land 21221						
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Citalopram and N	the mode of dying, such as cardiac of ortriptyline Toxi	r respiratory arrest, shock, or heart	Approximate interval						
/Medical examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ascular Disease		Death						
ે	Sequentially list conditions, b.									
iner	if any, leading to immediate Cause. Enter Underlying Cause Due to (or as a consequence of):									
ted insit	(Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):									
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50, te be e nysicial s burial	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery						
687 ertifica ding ph e as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 1 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna	ancy Month	Day Year						
box 68760, the death certificate be execut to the attending physician and ched for use as the bunial - raphysician/Medical	1 Yes 2 No 9 Unknown Pregnant at time of death 5 0	Other (Specify)								
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physicifunctal director, page 2 should be detached for use as the bunners! To Be Completed by Physician/Med		underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 P							
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safe death. 11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.				autopsy findings available						
Records, The law requires ficate has been sig, page 2 should be			performed? death							
		26.Place of Death (Check	1 Yes 2 No 1 V	Yes 2 No						
Vital ysician his cert directo	examiner? Hospital: 1 Inpatient 2 FR/Outpatie	Other -	ng Home 5 Residence 6 Ot	ner: Scene						
of \officers of Physical After the uneral of T. T.	27 Manner of Death 28a, Date of Injury 28b, Time of	of Injury 28c. Injury at Work?	28d Describe how injury occurred accidentaly over							
Sion Mtendi death. ctor:	Pending Investigation 1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, st	ou am =	prescribed medic	ations						
Division o spital or Attending nours after death. neral Director: After filled in by the fune.	3 Suicide 6 Could not be determined (Specify) Residence		28f. Location (Street and Number or or Town, State) 624 Oak Aberdeen, Md.	Ct.						
P P P P P P P P P P P P P P P P P P P		curred at the time, date and place, and	d due to the cause(s) and manner as s	tated.						
To the Ho within 24 To the Fu completel	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurred 29c. License number	29d. Date signed (
	29b. Signature and title of certifier	O.C.M.E.	January 30, 20							
No (5)	30. Name and address of person who completed cause of death (Item 23a)			-						
Beno.	Melissa Brassell, MD Assistant Medical Examiner 900	W. Baltimore Street, Baltimo	ore, MD 21223							
Stat Registra		ale								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 23(7 3:30 PM Physician/ MARY tox LYLES FANNIE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Sprungs Montgomer Silver 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Month, Day, Year 34 PREDERIVE Min. 56-5997 1 M 2 F 72 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f shown notified at 10c. City, Town or Location 10a. State 10b. County with the Maryland Director MUNTGOMORY MD. 1 Yes 2 No 6 ACMUNDONIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò must be r Funeral TORRACE APT 20874 USA BRARCLIFF 13109 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14 Race - American Indian 11. Marital Status "natural", or ite Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ✓ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) PRIVATE Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the Jonee. Home's CARE- GIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FANNIE BUTLER RUBERT MURRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13109 BRARCUFFTORMIE HOT 301 GERMANDUM MD 20374 (itusa) TEDDY LYLLES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ROCKVILLE MD. JAN. 4, 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS FUN TOME 21. Signature of Funeral Service Licenaes Collin 110 WEST SOUTH ST FREDERICK MD 21701 Buy 2. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiae arrhythmig Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) a ending physician and fruse as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? thrombocytopenia 2X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? leukemia 24a. Was an performed Yes 2 2 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗶 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <u></u> Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year) MD 68374 30/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Rd. Suite 630 Betnesda md SHUDDS MD.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0

20817

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:38 M Month Physician/ 01 Troy A. Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) unk **Funeral** Aug 2, 1965 Hours **Director** 1 🕅 M 2 🗆 F 229-23-4506 46 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at 10b. County Director notified 1X Yes 2 No Baltimore MD Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21215 3455 Cottage Avenue #B death 12. Was Decedent Ever in U.S.UNK
Armed Forces?

1 Yes 2 No 11. Marital Status unk 14. Race - American Indian, Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Rayvonne Foster - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ piration oneumana disease or condition Medical resulting in death) **Examiner** acidosis Squentially list conditions if any, leading to immediate cause. Enter Underlying Examine Lhabdonu Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Other (specify) Month Dav Year ed by the ar s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No 1 Tes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Residence 6 \(\sum_{\text{Other}}\) Other (Specify) 2 X No 1 Yes ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natura. Accident Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Univ PICIN

AT2438946 DIG

22/2012

Bathmere MD 21218

in

2. Registrar's Signature

201 E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charmian Stitambalam

FEB 0 1 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Raymond Richard Leight TANUAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE BALTIMORE HOSPITAL CENTER OSEDALE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 Days Hours July 20 Maryland 214-74-9040 54 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director MD Baltimore Nottingham 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be 1 Funeral 4 Meadow Creek Court 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married þ し E / ら H T ト ス・C H A R D Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lawrence Leight Vera Lotz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 4 Meadow Creek Court, Nottingham MD 21236 Darlene Leight 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 2/1/2012 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Hanover, MD 22. Name and Address of Facility Latimore Funeral Services, PA 21. Signature of Funeral Service Lice see 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EP. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Lause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affired feath.

To the Funeral Director Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1 Yes 2 □ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 U Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 055034 1-30-2012

Registrar

JACQUES

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FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONAWAY

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Aaron David Low	Ū	1- For State	State	of Marylan		ıπment o <i>tificat</i> e o				an No	201	2 0253	
Physicia		Registrar 1. Decedent's Name (Firs	t, Middle,La	ast)					2. Date of Dea		Year	3. Time of Death	
Medical Examir	ner	AARO			OWINGE:			- Landing	Month January 2			1337 hrs	
		4a. Facility Name (if not in 8000 Washingto					Elkrid	own, or Location o ge	or Death		County of Death oward	1	
Funeral		5. Social Security Numbe	r 6. 9	Sex 7.	Age (In yrs. la	ast birthday)				irth(MM/D		thplace (State or	
Director		216-58-4141	L 12	Ω¥M 2 F		46 Yrs	Month:	Days Hours	Min. 02/12,	/1965	Foreig	untryMARYLAND	
any	ı	Usual Residence of Dece	dent		I10c City	Town or Local	tion					10d. Inside City Limits	
. .		MARYLAND	HOWAF	D CO	1.55. 5.13,			ELKRIDGE	7			1 Yes 2 No	
larylan 18a-f s	Director	10e. Street end Number	HOWAI	Ф 00	<u> </u>		10f. Zip			10g. Citize	en of What Cou	ntry?	
death with the Maryland or items 23a or 28a-f show must be notified at once.		7880 V	VASHIN	NGTON BLVI)			21075		U.S	S.A.		
th with	uneral	11. Marital Status 1 Never Married 2	Marrie	12. Was Decede	es?	S. 13. Wa	es, specif	nt of Hispanic Ong / Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0- 1	 Race - Amer White, etc. 	ican Indian, Black,	
", or it	41		_	1 X Yes	² № 83/85	1	Yes 2	No specify:		s	Specify: WHIT	re l	
ours af	d b	15. Decedent's Education		or Dates:			nt's Usual (Occupation (Give king life, DO NOT)			nd of Business/		
6 n 72 h	Completed	Elementary/Secondary	(0-12)	College (1-4	or 5+)				use retired)				
-003 1 withi giene.	Ē.	12yrs 17. Father's Name (First,	Middle, Las	2yrs		BAJ	LL BO	NDSMAN 18.Mother	s Name (First, Middle,		SELF Surname)		
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	HARRY LOWIN		,				JEAN	NE LOWINGE	R	·		
D 21 hould is man	의	19a. Informant's Name/Re	elationship ((Street and Num	ber or Rural Route Nu	mber, City			
, MD and 2 shore ealth and cm 27 is reaumatic		Sue Lowinger 20a. Method of Dispositio	r/Ex-V	Vife	20b. F	3340 Place of Dispos			., Ellicoti		City, Md., 21043 20c. Location - City or Town, State		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injary or other traumatic event, the Medical Examiner must be notified at once.		1XX Burial 2 Cre	emation 3	_	State	crematory or ot	her place)		00 00 10		NGG WIT	T.G. MARWI AND	
Balting permit. Pa Departmen Important injary or	-	4 Donation 5 0 21 Signature of Funeral 9			GA	RRISON 22,1			02-03-12 COMMUNITY			LLS, MARYLAND	
E Post in the second se	$\frac{1}{2}$	DALLOW (1					W NORTH A		I FUN	IERAL H	ME P.A.	
Physician /Medical	7	25 Fart I. Enter the dise failure. List only on			ed the death.	Do not enter t	he mode o	f dying, such as ca	ardiac or respiratory ar	rest, shoc	k, or heart	Approximate Interval Between Onset and	
Examiner		Immediete Cause (Final or condition resulting in d		Asphyxia Due to (or as a co	nsequence of	F):						Death	
. ~	.	Sequentially list condition	15,	Hanging									
	ji.	if any, leading to immedia cause. Enter Underlying	Cause	Due to (or as a co	nsequence of	n:							
ed nsit	Examiner	(Disease or injury that init events resulting in death)	Last	Due to (or as a co									
and and	<u>re</u>												
760, ficate be exe physician is the burial -		IF FEMALE:		23c. If yes, out	come of pregi	nancy				23d.	Date of deliver	<u> </u>	
OX 687 eath certific	cian	23b. Was decedent pregna past 12 months?	ant in the	1 Live birth	at time of de	oth -	etal death ther (Spec		pregnancy	\ \	Month I	Day Year	
Box 68760, e death certificate be the attending physic of for use as the burned for use	lysi	1 Yes 2 No 9 Unknown 9 Unknown											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	P P	Part II. Other significant	conditions	contributing to de	ath but not re	esulting in the	underlying	cause given in Par				the cause of death?	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Completed	-							24a. Was			itopsy findings available	
e law re has be ge 2 sh	直									psy ormed? 2 ✔ No	death?	completion of cause of	
tal Rec	60	25. Was case referred to	medical				2	6.Place of Death (1		
Vita hysicia this cer	E P	examiner? 1 ✓ Yes 2 1	No		atient 2	ER/Outpatien			Nursing Home 5	-		r: Scene	
n of Vi ding Physi h. : After this		27. Manner of Death 1 Natural 5	Pending	28a. Date of I FOUND: Da	njury y,Year)	28b. Time of FOUND:	Injury 2	8c. Injury at Work? 1 Yes 2 ✓	Subject for				
isior]Cat	2 Accident	Investiga	28e Place of		1315 hrs ome, farm, stre	et, factory,	office building, etc		(Street and	d Number or Ru	ıral Route Number, City	
Divis Hospital or A 24 hours after Funcral Dire	Certification:	4 Homicide	Could no determin		lotel/Mote	ı			or Town, 8000 Washir	State) ngton Boi	ulevard Room	109, Elkridge, MD	
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier (Check only one) Certif	ying Physic	cian: To the best of	my knowledg	ge, death occu	rred at the	time, date and pla	ce, and due to the cau curred at the time, date	ise(s) and	manner as stat	ed.	
To the within To the comple	Medical	29b. Signature and title of		and manner state	rd.			License number	and the care		ate signed (Mo		
May /		ande	(O.C.M.E.			ary 24, 201		
PX M.	ł	30. Name and address of						-					
		Ana Rubio MD.		ant Medical Exa			imore S	treet, Baltimoi	re, MD 21223				
Sta Regist	ate rar	31. Date filed (Month, Da)	112"	32. Regis	trer's Signatu	A Comment							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G924, 2/1/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MCCAIN 2012 РМ 7:25 HAZEL JANUARY THELMA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S FORESTVILLE 3743 DONNELL DRIVE #301 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number . Age (In yrs. last birthday) Days Hours Min JAN 11 1934 1 M 2 V F Months 78 214-30-2102 MARYLAND Yrs. **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Director FORESTVILLE MD PRINCE GEORGE'S 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20747 3743 DONNELL DRIVE #301 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Madical Office. by 1 Never Married 2 Married Yes 2X No BLACK If Yes, Give Year or Dates 1 Yes 2X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT HOUSEKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DOROTHY DOUGLAS GEORGE DOUGLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8652 CONCORD DRIVE JESSUP, MARYLAND 20794 TERRY L. MCCAIN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2012 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 2/3/2011LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility Reche 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the divelace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of leart fail in. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition Physician/ ATHEROSCLEROSIS Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed DIABETES MELLITUS TYPE I Physician/Medical PERIPHERAL ARTERY DISEASE Division of Vital Records, P.O. Box 68760 the t anding p. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ANEMIA Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🔼 No Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 A Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide determined filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complet only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D42049 FEBRUARY 1, 2012

DHMH 17 Rev 7/2009

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State Registrar AFAIN G.

CHAMPALOUX MD 14314 OLD MARLBORO PIKE UPPER MARLBORO, MARYLAND 20772

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 28 1:24 РМ January Mary Patricia McCarthy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospice of the Chesapeake Harwood If Under Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Month, Day, Year) Nov 4, 1943 Min Director Washington, DC 579-58-1402 1 M 2 X F 68 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Cheverly Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 USA 3126 63rd Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black White etc ģ 1 X Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) postal clerk Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o John Joseph McCarthy Josephine Yoch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Deer Run; Enid, Oklahoma 73703 19a. Informant's Name/Relationship (Type, Print) Sheila Morris - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 0 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Sign store of Funeral Servi 22. Name and Address of Facility State Anatomy Board Renata 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law re 24 hours ofter death.
Funeral Director After this certificate has be autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ပ 1 🗌 Yes 2 🗗 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work?
1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 L Suicide 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) d title of cert 29c. License number Signature 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Ye FEB 0

2012

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	State of M					_		_	•
		For State Registrar		State of M	aryiani	-	rificate of	Health and Death		Reg. No	2111	2 02537
Physicia Medic		1. Decedent's Name	1	roud N	nal	01-	Jr.		2. Date of De. Month		VO 2 Year	3. Time of Death 7/5 A M
Examin		4a. Facility Name (if	not institution, give	street and number)		1	4b. City, Town, o	or Location of Deat	th ·		. County of Dea	
Funeral Director		5. Social Security Nu 219-54-0		9x 7. Ag	e (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th	g. Bir	thplage (State or Foreign ountry) aryland
		Usual Residence of 10a. State					-1:		march (, 1	950 11	
Marylan 18a-f sh tified a	recto	MD	Washir	ngton		, Town or Loca [agerst						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
s 23a or 2	Funeral Director	10e. Street and Num 18014	_{nber} Marsh Pik	te			10f. Zip Code 2174()			tizen of What Co SA	ountry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	11. Marital Status 1 🖾 Never Marrie 3 🗆 Widowed		12. Was Decedent E Armed Forces? 1 Yes 2 L If Yes, Give Year or Dates.		lf '	as Decedent of H Yes, specify Cub	Hispanic Origin? (Sean, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh:	te, etc.
hin 72 hou ne. than "nat u ne Medica	Completed	(Special Special Speci	15. Decedent's E cify only highest gra anday (0-12)	ade completed) College (1-4 or 5	5+)	(Give ki life. DO	NOT use retired	during most of wo	rking	16b. K	(ind of Business	·
filed wil al Hygie d other went, th	Be	17. Father's Name (F	First, Middle, Last)	0		000	K	18. Mother's Na	me (First, Middle,	Maiden		ndustry
d Ment marked matic e	υ	James E. 19a. Informant's Na	11wood Ma					' 	Dolores			
nd 2 she ealth an m 27 is ner trau		Debra A	Ann Smith	- sister				tand Number or Ru ve #1FSW;				
Page 1 ament of H tant: If ite		4 💢 Donation	Cremation 3 C				atory or other pla		Date		ocation - City or	r Town, State
permit Depart Import any inj once.		21. Signature of Fun	neral Service Licent Onald S	Marke, Dir	ector	_		ess of Facility S1 Baltimore		-		21201
Physician/			t failure. List only o Final	plications that caused ne cause on each line								Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)		Due to (or as	a conseque	ence of):	Deme	nta				
led nsit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying iinjury	Due to (or as	a consequ	ence of):						
ite be executed hysician and he burial-transit	g	that initiated events resulting in death) L		d	a consequ	ence of):						
To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. with 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the I completed filled in by the funeral director, page 2.	Physician/Medio	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	ncy			23d. Date of de Month	olivery Day Year
is that the		Part II. Other signifi	icant conditions o	ontributing to death b	out not resu	Ilting in the un	derlying cause g	iven in Part I.				o the cause of death?
require been s should	leted	Dich	2 70 C	Mo II i L					24a. Was		□ No 3 □ F	Probably 4 Unknown utopsy findings available
The law cate has page 2	Completed by	Dias		rent	U.S				auto _l perfo 1 Yes	psy ormed? 2 X N	death?	completion of cause of
rsician: s certific director,	To Be	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:	ant 2 🗆 I	ER/Outpatient	Ott	Place of Death (Che	eck only one) Home 5 🗆 Resid	donas 6	C Othor (Spor	oi6/)
iing Phy .r Affer thi funeral o		27. Manner of Death	5 Pending	28a. Date of inju (Month, Day	iry	28b. Time of injury	28c. Inju wor	ry at rk?	28d. Describe h			uny)
lor Attenc after death Director:	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined					Yes 2 No	28f. Location (S City or Tow			ural Route Number,
e Hospita 24 hours e Funeral	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or investig	gation, in my opin	ion, death occurred	at the time, date a	and place	e, and due to the	cause(s) and manner stated.
To th Comp	N.	29b. Signature and t	~	G 00	4 0		29c. Licens				te signed (Mont	
		30. Name and addre	ess of person who	completed cause of d	leath (Item	23a) (Type, Pr	int)	187 18		1-:	30-20	10
		Michel 31. Date filed (Ment)	le Eyl	er 140	14/	rarst	Pike	. Haje	Stavn	Mr	1217	42
Staf	е	O I. Date filed	חיית יש"ח אים	32. Registra	aı ə əiginatl	are a		3				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02538 State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 1148 AM NELLIE MILLER JAN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-38-294 **Director** 1 🗆 M 2 🕱 F 71 Yrs. 01-13-1941 Usual Residence of Decedent show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral RIGGS permit Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "" any injury or other traumatic 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedon Armed Forces? 1 ☐ Yes 2 💆 No þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC to USE WIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည WALTER LEE GAINER Idele LYNCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 Waterwheel SOVARE. KANDALLSTOWN, MD. 21133 ASSANDRA INGRAM (DAUghter 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/3/12 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGH N GREENE FUNERAL SUS 21. Signature of Funeral Service Licenses ROAD. BANIMORE, MO. 21212 MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) BREAST CANCER METASTATIC Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, KIDNEY INJURY AYPOXIA MAZIGANT PLEBRAZ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EFFUSIONS LUNG METASTASES 2 1 No 1 Yes Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Detrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) R133788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIREET SUSAN OTREMBA BALTIMORE MARYLAND

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8.per fh, g924 2-9-12 sm
State of Maryland / Department of Health and Mental Hygiene 2012

		_1	For State Registrar		Certif	icate of D	eath	Re	eg. No.		
	Di	,	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia Medic	al		Gerry A. Mack				January	7 29, 2	2012	12:01 A.M
	Examin	er	4a. Facility Name (if not institution, give stre				Location of Death		4c. Count		Arundel
STE SEE			8025 Fort Smallwo	7. Age (In yrs. last		f Under 1 Year	If Under 24 Hrs.	8. Date of Birth	<u> </u>	9. Birth	place (State or Foreign
	Funeral Director		011 01 0010	м 2 🖾 ғ 🛙 73	Yrs.	lonths Days	Hours Min.	01/08/	/ †939 2012	Cour	Maryland
	and show	ō	10a. State 10b. County	10c. City, T	Town or Locati	on				- I	10d. Inside City Limits
	Aaryla Ba-f s tiffied	Director	Maryland Anne An	rundel Ba	altimor	re					1 Yes 2 X No
	e filed within 72 hours after death with the Maryland tall Hyglene. And Hyglene. And chter than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 8025 Fort Smallwo	od Road Apt. D		10f. Zip Code 21	1226	1	0g. Citizen of U.S.		ntry?
	tems	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was	s Decedent of His	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - Americ	
036	s after d ral", or i Examin	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		Yes 2 No			Specif		nite
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212	within giene. er thar t, the N		Elementary/Secondary (0-12)	College (1-4 or 5+)	Homem					n Hor	ne
and	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Josep	h Cook			18. Mother's Nam		naiden Surnan Ot avai		e)
Baltimore, Maryland 21215-0036	2 should be file Ith and Mental I 27 is marked or r traumatic eve		19a. Informant's Name/Relationship (Types Elizabeth Lishka		19b. Mailing /	Address (Street a	nd Number or Rura Beach Roa	al Route Number,	City or Town,	State, Zip Mary	Code) land 21122
nore,	Page 1 and 2 nent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place	ce of Dispositi netery, cremat	ion (Name of fory or other place rt of Je	9 2sus 02/0		20c. Location	-	own, State Maryland
Baltir	permit. Page 1 a Department of H Important: If ite any injury or oth	9	21. Signature of Funeral Service Licensee		22. N	lame and Addres	s of Facility Go:	nce Fune	ral Se timore	rvice , Mar	, P.A. yland 21225
ı			23a Part 1. Enter the disease or complice shock, or heart failure. List only one	cations that caused the death.							Approximate Interval Between
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	icate be executed g physician and as the burial-transit	al Exa	that initiated events cresulting in death) Last	Due to (or as a consequer	nce of):			·			
68760	physic physic the t	edic	d				· ·				
Box 68	ath certific attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	Bc. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 📙 🛭	Ectopic pregnanc Other (specify)	у			ate of deli Nonth	very Day Year
P.O.	requires that the dec been signed by the s should be detached	by Phy	Part II. Other significant conditions con	tributing to death but not result	ting in the und	derlying cause giv	ren in Part I.				the cause of death?
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of Vi	ng Physi fter this c uneral dire	ate: To	1 ☐ Yes 2 ☒ No '''' 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 □ Inpatient 2 □ E	R/Outpatient 28b. Time of injury	3 L DOA 28c. Injun	4 ∐ Nursing H y at ?	ome 5 X Reside 28d. Describe ho			fy)
Division of Vital Records,	or Attendi fter death birector: A in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree		Yes 2 No	28f. Location (St City or Town		ber or Rur	al Route Number,
Ξ	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical C	(Chook 2 Madiesal Evamine	cian: To the best of my knowleder: On the basis of examination of	and/or investig	ation, in my opinio	on, death occurred	at the time, date ar	nd place, and (due to the c	ause(s) and manner stated.
	To the within 2 To the comple	ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of my	y knowledge, d	29c. License	e number		29d. Date sigr	ned (Month	, Day, Year)
0					_/_	D18.	508 		Janua:	ry 30	, 2012
1			30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Pri ain Hid	nt) Shway Su	ite 106	Glen Bur	nie. M	arvla	nd 21061
	V Sta		31 Date filed (Month, Day, Year)	32. Registrar's signatu		u					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland /		artment of F		nd M	•	-	2012	025	1. 0
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate of E	Jeath		2. Date of Dea	Reg. No.	2012	3. Time of De	
	Physicia Medic		STEPHEN	MELV	N					Month O (Day	2012.	1	
	Examin		4a. Facility Name (if not institution,		. 603		4b. City, Town, or		Death			County of Deat	h	
	Funeral		Montgowery Hospice 5. Social Security Number		e (In yrs. last bir	thday)	If Under 1 Year	If Under 24		8. Date of Birt	h	Ontgom 9. Birl	hplace (State or F	oreign
	Director		215 - 72 - 6099	1 🔀 M 2 🗆 F	53	Yrs.	Months Days	Hours	Min.	(Month, Day		Was	Tington I	
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	eation			02 -1	, 10	0	10d. Inside City l	Limits
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	ith the 23a or it be n	ralD	10e. Street and Number 18612 Cross Co	untry Lane			10f. Zip Code 20879					zen of What Co J SA	untry?	
	eath w tems 2 er mus	Funeral Director	11. Marital Status	12. Was Decedent B			Vas Decedent of His	spanic Origir				4. Race - Ame		
36	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	-No		Yes, specify Cubar		Puerto R	ican, etc.)	8	Black, White Specify: whi		
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Balti	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Source Lin		ector		Name and Addres				-		21201	
Н	- 11		23a. Part 1. Exter the disease, or o shock, or heart fallure. List or	complications that caused ly one cause on each line	the death. Do	not ente	r the mode of dying	g, such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between	
1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Adencia	a consequence		the Park	reas					Onset and Dea	atn
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or vital Records,	The law a cate has to page 2 s	Completed								24a. Was a autop perfo	rmed?	prior to death?	topsy findings ava completion of caus	
Ta	sician; certifi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	4 \(\pi \) 50/0	4	Othe	er:				2 1 0.1 (0.1)	ifu Hospic	~
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lon	ttendir death. tor: Af the fu	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could n	ation of he			M 1 □	Yes 2 N	-	26 1		A1	- I Don't North	
UIVISION	al or A s after I Direct		4 ☐ Homicide determir	28e. Place of Injubulding, etc		airn, Stre	et, factory, office		28	City or Tow		Number or Hui	al Route Number,	
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_	To t To tl	_	29b. Signature and title of certifier	10 -			29c. License					signed (Month		
			30. Name and address of person w	ho completed cause of de	eath (Item 23a)	(Type P		7142			1 - 1	9-20	12	_
			G. Glowan	MD 6001	Muna	(Rd.	De	how	WĪ)		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	bark	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8Perff, G924, 2/6/2012, WS

State of Maryland / Department of Health and Mental Hygiene

1 - For State amend items 25, 27 per me g924 2-16-12 vt

Reg. No. 20 2 Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January January 1:25 PM MISTER Medical 4a. Facility Name (if not institution, give street and number) vn, or Location of Death 4c. County of Death Examiner Shock Center UNIVERSITY mulan Baltimore N/A If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birt 8-28-196 / 9. Birthplace (State or Foreign 7. Age (In yrs. last birth ay **Funeral** 1 M 2X F Months Hours "Maryland Director 213-80-3912 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Baldwin Md Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Funeral 13604 Brookline Road 21013 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert R. **Holthaus** Joan Bruns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. once. Baldwin, Maryland 21013 David F. Mister/Husband 13604 Brookline Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2/1/12 Hilltop Service Corp. Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death nemorrhag Physician/ disease or condition Medical resulting in death) Examiner accident rennovascalar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine the burial-transi and that initiated events resulting in death) Last EXAM been signed by the attending physician PPROVED BY MEDI Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 CERTIFICATION for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed' this certificate 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 X Yes ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of Manner of Dear injury , *Day*, 28b. Time of Certificate: 28c. Injury at scribe how injury 24 hours after death.

Funeral Director: After Natural 5 Pending work? 1 🔲 Yes all down starrs Accident UNKNOWN 2 **M** No Investigation 21 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Number. determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configure Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and tit Date signed (Month, Day, Year)
29 12 at 223PM 29c. License number 290 youn, MD ļ 100983 Name and address of person who completed cause of Baltinuere, MD 21201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Odessa moon 7:354 Barunn 2012 Medical a. Facility Name (if not institution, give street and number) County of Death Examiner andallstown Baltimore ttospice If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Director 1 M 2 F 81 2-2-1930 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City Town or Location at **Funeral Director** notified MD1 Yes 2 No 10g. Citizen of What Country? Medical Examiner must be USA 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during m life. DO NO) usinetired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be Middle, Last) ၉ City or Town, State, Zip Code) 21214 Villiams 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) re of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End. Stage bement in Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): use as the burial-transit and Due to (or as a consequence of): physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death for in the past 12 months?

1 Yes 2 No 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 4 Nursing Home 5 Residence 6 Other (Specify) enthuspill Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. I Director: Aft Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29/12 MIKM MODERN MID DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore NS RY aparte Mo

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registra 's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 12:50 01 30 MARTIN MOLOCK E. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOSEPH RICHEY HOSPICE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) 216-16-1657 Director 87 1 🗶 M 2 🗆 F 01-20-1925 MD Usual Residence of Deced ms 23a or 28a-f show must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 □ No MD BALTIMORE 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2107 W. LEXINGTON STREET 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ō 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 'natural" 3 Widowed 4 Divorced WW11 Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed wi<u>thin 72</u> tal Hygiene, dother than " 2 YR. (1-4 or 5+) Elementary/Secondary (0-12) U.S. GOVT MICRO BIOLOGY TECH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important If item 27 is marked any injury or other traumatic evonce. ည MARTIN LEE MOLOCK EDITH DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 LEXINGTON ST., BALTO., MD 21223 SADIE M. MOLOCK/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MILLS, MD 2-06-2012 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Biset and Dealing Immediate Cause (Final Physician/ erepursamon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Examiner Due to jor as a consequence of attending physician and d for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atterpage 2 should be detached for Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform this certificate **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date/signed (Month, Day, Year) eellu 01/30/2012 hd address of Gersch who completed cause of death (Item 23a), (Type, Print)
dell w Iglehar of III me 6301 N Charles Street Battonice, me 21212

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

lartine Molo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:10PM 2012 January Rufus L. Mason Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Hours Director 215-68-1050 1 🔀 M 2 🗆 F 05/13/1958 | Maryland 53 ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County Director 1 Yes 2 KNo Hagerstown MD Washington Co. 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. Baltimore St. Apt710 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16b. Kind of Business/Industry Horn And Horn 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working nould be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria 12th Grade Cook Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Isabella Heath Rufus Mason Sr. of Page 1 and 2 shous.

of Health and Mr.

of Health and Mr.

of Signature of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 168 Shropshire Ct., Reisterstown, MD21136 Sheila Mason(Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of I-Important: If ite any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD on-site Crematory 01/30/12 21. Signature Funeral Service Licent Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limitediate Cause Tripal seases or conditions. Approximate Interval Between Onset and Death Physician/ iogen ard isease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of nding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) signed by the ail Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Œ. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral death. 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0069606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD KODUAH # 306, Hagerstown 324 East Antietam St. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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		-	For State of Registrar	Maryland / I		rtment of I tificate of I		Mental Hy	giene Reg. No.	2012	02545
ī	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Medic	al	Kathryn Ann Redmon Nie 4a. Facility Name (if not institution, give street and numb			4h City Town 0	r Location of Deal	Januar		2012 County of Death	3:00 P M
	Examin	er	Holy Cross Hospital	51)		Silver :				ontgomer	У
	Funeral			. Age (In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, Year)	9. Birth	place (State or Foreign http:// lington, DC
4	Director		220-56-4496 1 □ M 2 🗓 F Usual Residence of Decedent	61	Yrs.			Apr 26	, 19:	ou wasn	ington, be
	/land f shov ed at	tor	10a. State 10b. County	10c. City, Tow	n or Loc	ation				1	10d. Inside City Limits
	e Man r 28a- notifie	Direc	MD Montgomery 10e. Street and Number	Silver	Spi	ring 10f. Zip Code			10g Citi:	zen of What Cour	1 Yes 2 No
	with th	Funeral Director	11901 Georgia Avenue			20902			USA	2011 01 111101 0001	
	nould be filed within 72 hours after death with the Manyland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at		11. Marital Status 12. Was Deced		13. W	/as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1	14. Race - Americ Black, White,	
36	after al", or	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date			☐ Yes 2 XNo			5	Specify: Whit	
9	hours natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)		. Decede	ent's Usual Occup	pation	arkina		nd of Business/In	
121	thin 72 ane. than ' ne Me	Som	Elementary/Secondary (0-12) College (1-4		life. DC	NOT use retired)	aumg moot er m		Ant	ique Sto	
Q 2	lled wil I Hygie other ent, th	Be	12 17. Father's Name (First, Middle, Last)		mer	-	18. Mother's Na	ıme (First, Middle,			TE
ylan	ld be fi Menta arked atic ev	욘	Harold Redmon				Helen F				
Maryland 21215-0036	2 sh tha tha trai	3	19a. Informant's Name/Relationship (Type, Print) John Redmon/Brother			g Address (Street Mahaska					Code)
Baltimore,	Page 1 and ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	cemete	ry, crem	sition (Name of eatory or other place)	natory 0	Date 1/28/12	l	dbine, M	
altii	permit. Page 1 Department of Important: If if any injury or o		21. Signatury of Funeral Service Licensee		22 GO	Name and Addre	ss of Facility Cremati	on Servi	ce 1	P.O. Box	784
ш	20 E # 9	Ш	Tevel F the hate	MO1251	Rev	verly I.	Heckrot	to DA	Clar		MD 21020 Approximate
П	Physician/		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each Immediate Cause (Final				19, 00011 40 941 410		,		Interval Between Onset and Death
	Medical	i i		ratory Fa		Le					
	Examiner	ř	Sequentially list conditions,	ructive Sl		Annea					
	ed	Examiner	cause. Enter Underlying Cause (Disease or injury Hypox	entilatio	- 1	vndrome					
	execur an and rial-tra		that initiated events C. — • • • • • • • • • • • • • • • • • •	r as a consequence							
90	cate be executed physician and the burial-transit	edical	d								
687	certifica ding p	n/Me	IF FEMALE: 23c. If yes, outcome 23c. If yes, outcom	ome of pregnancy		1 =				23d. Date of deliv	very
Box 68760	requires that the death certific been signed by the attending Is should be detached for use as	Physician/M	in the past 12 months?	irth 2 🗌 Fetal deat ant at time of death wn		Other (specify)	cy			Month	Day Year
P.O.	that the led by detac	by Ph	Part II. Other significant conditions contributing to de	ath but not resulting	in the ur	nderlying cause g	ven in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
ds,	quires en sign ould be							. 1 🗆	Yes 2		bably 4 XUnknown
Division of Vital Records,	The law rea ate has be page 2 sh	Completed						24a. Was auto perf		prior to co death?	opsy findings available ompletion of cause of
E E	ysician; Ti is certifical director, p	BeC	25. Was case referred to medical examiner?				lace of Death (Ch		2 04 140	,,	
Ę	Physica this carral dire	은	1 Yes 2 X No Hospital: 1 X le 27. Manner of Death 28a. Date of	npatient 2 ER/O	utpatien Time of	nt 3 DOA Oth	4 ☐ Nursing	Home 5 Res		Other (Specif	y)
0 U	nding Ph tth. : After th e funeral	cate			injury	wor	k? Yes 2 ☐ No	Zou. Describe	now injury	, cocarred	
ivisio	or Attend after death Director: /	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of buildin	of Injury - At home, fig, etc. (Specify)	arm, stre	eet, factory, office			(Street and wn, State)	d Number or Rura	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	29a. Certifier (Check conly one) 1	of examination and/	or invest	igation, in my opin	ion, death occurre	d at the time, date	and place,	, and due to the ca	ause(s) and manner stated.
	To th within To th сотр	2	29b. Signature and title of certifier			29c. Licens	se number			te signed (Month,	
			Jagns, 110				8912		1/1	0/12	
	21		30. Name and address of person who completed cause	e of death (Item 23a)	(1ype, P	Forest	6/80 /	6 5:1	Spr.	MO 2	20910
	Sta Registr			gistrar's Signature	2		1,-1×21		,		
	3			AND A MARKET CAPTURE	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State of M	aryland / Departm		ınd Mental Hy	giene		
	-		Registrar Decedent's Name (First, Middle, Last)	Certificate of Death Reg. No. 2					
	Physicia Medic	1/	DELO LES E.	OLIVER		Janu	Day 27 2	6:00 PM	
interior.	Examin	er 4	a. Facility Name (if not institution, give street and number) WUYU LLQ ical	4b. (City, Town, or Location of	f Death	4c. County of		
	Funeral	2	Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) If U	nder 1 Year If Under 2 ths Days Hours	24 Hrs. 8. Date of Bird Min. (Month, Da	h S	9. Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	72 Yrs.		01/10/	1940 M	Maryland	
	th the Maryland 3a or 28a-f show t be notified at	to	0a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits	
	Mary 28a-1 notifie	irec	MD N/A		imore Zip Code		10g. Citizen of Wh	1 X Yes 2 No	
	with the 23a or ist be r	ral	Oe. Street and Number 244 St. Matthews St.		21202		U.S.		
	eath w tems :	by Funeral Director	1. Marital Status 12. Was Decedent Armed Forces?		ecedent of Hispanic Orig	in? (Specify Yes or No-	14. Race -	American Indian, White, etc.	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 If Yes, Give	No _	es 2 🙀 No Specify:	, 1 4010 1 11041, 5157	Specify:	Black	
21215-0036	nours natura ical E	Completed	15. Decedent's Education	16a. Decedent's	Usual Occupation	C. other	16b. Kind of Busi		
215	iin 72 l ie. han "r e Med	g l	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 1)	5+) life. DO NO	f work done during most Fuse retired)	or working	N/A		
121	d with Hygien ther th	as I-	6th Grade 17. Father's Name (First, Middle, Last)	Home	maker	er's Name (First, Middle,			
Maryland	be file ental H ked o ic eve	10	Calvin L. Vaughn			da L. Bai			
ary	thould and M is mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	dress (Street and Number			te, Zip Code)	
Σ,	nd 2 s lealth m 27 i		Yvette Oliver(daughter		hetford R			ID 21286	
ore	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposition cemetery, crematory	or other place)	Date		City or Town, State	
Baltimore,	permit. Page 1 a Department of h Important: If ite any injury or ot	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee / / / /	King Mem.	Park 10 park Address of Facility pn H Bro		Baltimo		
B	permil Depar Impor any in		Wiehrich N. Will	10ML 2140	N. Fulto	n Ave., I	<u>Baltimor</u>	e, MD 21217	
	Physician Medical Examiner	iner	Due to (or as Sequentially list conditions.	a consequence of):				Interval Between Onset and Death	
09	ate be executed ohysician and the burial-transit	dical Examiner	Cause (Disease or injury	a consequence of):					
. Box 687	To the Hospital or Attending Physician ; The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Me		2 ☐ Fetal death 3 ☐ Ector at time of death 5 ☐ Oth	opic pregnancy er (specify)		23d. Date Mon	of delivery th Day Year	
s, P.O.	ires that the signed by the deta	d by Pł	Part II. Other significant conditions contributing to death	but not resulting in the underl	ying cause given in Part	1. 23e. Did		oute to the cause of death? 3 Probably 4 Unknown	
Division of Vital Records,	sician; The law requ certificate has beer lirector, page 2 shou	Complete				24a. Was auto perf 1 \(\sum \text{Yes}\)	opsy pr	ere autopsy findings available ior to completion of cause of eath? Yes 2 No	
ita	Physician; T r this certifica ral director, p	Be	25. Was case referred to medical examiner?		Oth	th (Check only one)	:	(0if)	
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ono	ttending F death. stor: After i	ficat	2 Accident Investigation	N	1 1 Tyes 2				
N	or Att	Certificate:		ijury - At home, farm, street, fa tc. <i>(Specify)</i>	actory, office		(Street and Number wn, State)	r or Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Euneral Director: A completely filled in by the fi	Medical	29a. Certifier Certifying Physician: To the best of (Check only one) 3 Certifying Nurse Practitioner: To the control of the control one of the control of th	examination and/or investigation	on in my onlinion death or	courred at the time, date	and place, and due	to the cause(s) and manner stated.	
	Го th e within Го the соптрЫ	Σ	only one) 3 Certifying Nurse Practitioner: To a 29b. Signature and title of certifier	the best of my knowledge, dear	29c. License number	are place, and add to		(Month, Day, Year)	
			*XNaz/LUU)	Attending	D5139	9	Jau. 2	1,2012	
			30. Name and address of person who completed cause of	death (Item 23a) (Type, Print)	MARE, M	D 21201	JEANE ATT	ME NAZ ARIAN, ME	
	Sta Registi		31. Date flood (Month, Day, Year) 32. Regist	trar's Signature					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PETERSON JANNIE IANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE RESIDENCE ON GREENBELT PRINCE GEORGE'S LANHAM 8. Date of Birth (Month, Day, OCT • 28 Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 🗆 M 2 💢 F Months 126-05-2375 94 1917 SOUTH CAROLINA Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State Director Yes 2 No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4103 MASSACHUSETTS AVENUE 20019 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. Š 1 Never Married 2 Narried 1 Yes If Yes, Give 2 💢 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK 3 Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the SOCIAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALICE NEAL BURNIE C. MCCARLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 and lis m 19a. Informant's Name/Relationship (Type, Print) 8828 EAST FORT FOOT TERRACE FORT WASHINGTON, MD of Health MICHELLE WADE / GRANDDAUGHTER 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State FOREST LAWN CEMETERY ! 2/4/2012 BUFFALO, NEW YORK Sonation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Fue al Service L 22. Name and Address of Facility Signature 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ MULTI-ORGAN FAILURE disease or condition resulting in death) Med. Examiner Medical Due to (or as a consequence of) SEPSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) DEHYDRATION Exami ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ENCEPHALOPATHY Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 X No 1 Yes 2 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by spinal stenosis Division of Vital Records, No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? arthritis 24a. Was an cate has I autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assistant Living Hospital: Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accider injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Codifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

To the Hos within 24 h

To the Fun

completed

29b. Signature and title

ARNULFO BONAVENTE MD 6409 SOUTH CRAIN HIGHWAY UPPER MARLBORO, MARYLAND 20772

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29d. Date signed (Month, Day, Year)

JANUARY 28, 2012

with the Maryland Palmer, Mary Baltimore, Maryland 21215-0036 SS KNOWN ahent

amend 5, per fh, g924 2-10-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 19a per fh g924 2-1-12 vt
State of Maryland / Department of Health and Mental Hygiene 2 1 2 02548 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PALMER Month Physician/ 04:30 PM BERNICE MARY January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** sinai Hospital of Caltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 1 M 2 F 85 1926 VIRGINIA April 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at Director BALTIMORE 1 Yes 2 No MA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö PARK HEIGHTS AVE APT 104 21215 USA 23a Funeral 5715 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status I Hygiene. other than "natural", or iter vent, the Medical Examiner Armed Forces? Black White etc. 1 Never Married 2 Married by 1 Yes 2 No Specify. Specify: BLACK If Yes, Give Year or Dates Completed 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BEAUTY Elementary/Secondary (0-12) College (1-4 or 5+) SALDUN BEAUTICIAN 12 TH of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LILLE BROWN GEORGE H. LEWIS permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) sister TROON CIRCLE MT AIRY, MD. DURIS GRAHM 303 20b. Place of Disposition (Name of cemetery, crematory or other place)
KIN 6 PARA Com. 20c. Location - City or Town, State 20a. Method of Disposition Date BALAMORE, MO Burial 2 Cremation 3 Removal from State Feb 6, 2012 4 Donation 5 Other (Specify) KIND 22. Name and Address of Facility GARY L. RUCLINS FUN. Home 110 WEST SOUTH ST FREDERICH MD 21701 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 day Physician/ Aspiration preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner day Small Bowel obstructur Sequentially list conditions Examiner cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Grastrointestinal bleed and the burial-trai Due to (or as a consequence of) physician 1 day Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be lactic acidosis Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Pulmonary embolism on anticoagulatum 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Hypertension certificate has be lirector, page 2 s autopsy performed?
1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural iniury 5 Pending Investigation hours after death. I Director: A
d in by the f 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D completely filled in Medical Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28,2012 Cechayslen Tamasho. RESODO January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+ Ballmore

DHMH 17 Rev 06-2011

State Registrar

Sinci Mospital

MD,

-Tamashiro

1 2012

Cecilia Yshii 31. Date filed (Month Day Year)

1 - For State Registrar Physician/ Medical **Examiner Funeral Director** 10a. State notified at Director 28a-f 10e Street and Number ö pe ms 23a (must be Funeral items 2 er than "natural", or iter the Medical Examiner by 3altimore, Maryland 21215-0036 Completed PENCHENSKI, BET Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be ပ Immediate Cause (Final Ph_sician disease or condition resulting in death) Medical Examiner Examine resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: the 1 ☐ Yes 2 ☐ Unknown þ Completed page 2 s this certificate Be examiner? 2 00 27. Manner of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26,2012 ANUARI John Michael Penchenski Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL at HASTON FASTON TALBOT . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Dec 12 Pay, Year) 33 NewryYork 78 105-26-5722 1 🗓 M 2 🗆 F Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits Talbot St. Michaels 1 ☐ Yes 2 🗓 No 10f. Zip Code 10g, Citizen of What Country? 24260 Oakwood Park Rd; Box 794 21663 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Aspect Forces?

14 Yes 2 No 1951

If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) police officer law enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Penchenski Olga Sorokata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Alice Penchenski - wife 24260 Oakwood Park Rd; St. Michaels, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🗓 Donation 5 ☐ Other (Specify) Signature Funeral Service 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Deter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death initially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes 2 N 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) mpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director, After of completely filled in by the funer 28d. Describe how injury occurred 1
Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pray titioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif elle 31. Date filed (Month, Day, State FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12:34 AM Physician/ CATHERINE PERRY januan 2012 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner of Balhmore Balmore City Sinai Hopital Carrena If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 212-44-7806 Usual Residence of Decedent 1 □ M 2 🔀 F **Director** MD 11-24-1945 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f shov 10b. County with the Maryland Director BALTIMORE must be notified 1 Yes 2 No MD 10g. Citizen of What Country? 10f. Zip Code Perry, o 10e. Street and Number Funeral 21215 23a USA AVENUE 3110 LEIGHTON Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 12. Was Decedent Ever in U.S. rmed Forces? Black White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BACTIMORE CITY SCHOOLS Elementary/Secondary (0-12) College (1-4 or 5+) ICHOWN CUSTODIAN Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental EVELYN JOHNSON GEORGE JORDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3722 HILLSBALE RD. GWYNN OAK. MD. 2120 7 19a. Informant's Name/Relationship (Type, Print) ANN HOLT (DAUGHTER) Ribert Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 2/7/2012 BATTIMORE, MD GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCUS 21. Signature of Funeral Service Licensee 4905 YORK ROAD. BAUTIMORE, MO. 21212 MO1555 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final pancrealins Physician/ Acute disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 Yes 20 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 2 No has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Cartifying Nurse Practitioner: To the best of my knowledge course at the time, date and place, and due to the cause's, and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) RES 000 January 28th 2012 · Centey suntamant 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Balling MD sinac Tamashio aulia ysmi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY □28,2042 Physician/ 3:30 рм PUPEK BRIAN DAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE DUNDALK 7508 DURWOOD ROAD If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** . Age (In yrs. last birthday) NOV. Day, 3 ^{ar)}1954 1 🌠 M 2 🗆 F MARYLAND 59 218-68-7359 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD BALTIMORE DUNDALK 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21222 U.S.A. 7508 DURWOOD ROAD items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: "natural", Completed 3 Divorced 4 Divorced WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALEXANDER PUPEK ANNA WASILEWSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sł Department of Health ar Important: If item 27 is any injury or other trau PAUL PUPEK/ BROTHER 119 WILLIAMS STREET, BELAIR, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/3/12 BALTIMORE, MARYLAND HOLLY HILL CEM. 4 Donation 5 Other (Specify) 21. Signature of Funeral Swice Licenses R INC. FUNERAL HOME AVENUE, BALTO., MD_ 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final acuta Physician) disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed 1 ☐ Yes 2 ☐ No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, i 25. Was case referred a medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PEREZ Day 7 701Z Month YNETTE 3:15 PM JAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE N/A Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthdav) 8. Date of Birth Maryland 1 □ M 2 🗓 F Days 219 42 0570 (Month, Day, Year) 09/20/1944 Director 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 28a-f Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 307 South Mount Street 21223 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. an "natural", or ite Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Mail Handler U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Harrison (Notavailable) 17. Father's Name (First, Middle, Last) of Health and Mental H
fitem 27 is marked ot
r other traumatic ever ည unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosendo Perez / Husband 307 South Mount Street Baltimore, Maryland 21223 Baltimore, t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 K Burial 2 Cremation 3 Removal from State Important: I any injury of Glen Haven Mem. Park 101/31/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mamerousiu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or none cause on each line. Immediate Cause (Final Onset and Death Physician/ FAILURE disease or condition resulting in death) RESPIRATORY Medical **Examiner** METASTATIC SQNAMOUS CELL LUNG CANCER TWO MONTHS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 💢 No signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ OBSTRUCTIVE SLEEP APNEA Records, To Be Completed 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy this certificate ☐ Yes 2 🗷 No 1 Yes 2 No Division of Vital I or Attending Physician: after death. Director, After this certific 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6
Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State

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Registrar DHMH 17 Rev 7/2009 RES 001

JAN 27

3001 S. HANOVER ST. BALTEMORE, MD ZIZZS

Weggenton,

WIGGINTON, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wristine

CHRISTINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elliot Stearns Pierce 29, 2012 January 9:14 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10705 Brunswick Avenue Kensington Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 027-12-6447 Director 89 1 **X** M 2 □ F Yrs Apr 30, 1922 Massachusetts Usual Residence of Decedent at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD Montgomery Kensington 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10705 Brunswick Avenue 20895 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. "natural", or iten edical Examiner 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces? Black, White, etc. by 1 Never Married 2X Married 2 No 1 ☐ Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1944-46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chemist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Clifford Ernest Pierce Mary Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina-Pilar Taillard/daughter 9619 Noche Vista Dr. NW, Albuquerque, NM 87114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 02/01/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Cerebrovascular Disease Years Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Et let orderlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Cther (specify) in the past 12 months?
1 Yes 2 No Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 XNo 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 🔲 Yes 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

requires that the death certificate be P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has Letely filled in by the funeral director, page 2 s

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Baltimore, Maryland 21215-0036

the Hospi hin 24 hou the Funer npletely fill	Medica	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, c 2 Medical Examiner; On the basis of examination and/or 3 Certifying Nurse Practitioner: To the Dest of my knowledge, c	Investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s) and manner stated
To T Com		29b. Signature and title of certifier Runand Wollen	29c. License number D09577	29d. Date signed (Month, Day, Year) January 30, 2012
201		30. Name and address of person who completed cause of death (Item 23a) (TRichard Polle, M.D. 10400 Connection	ype, Print) Cut Ave. #606 Kensingto	on, MD 20895

31. Date filed (Month, Day, Year)

32. Registrar's Signature 1) pare

State

Registrar

City or Town, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 25, 2012 Marie 0810 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehabilitation and Norshy Center andy Contagoner 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Min. Sep. I, 1935 Director 204-28-5943 76 Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18131 Slade School Road 20860 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electric Company Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Franklin Steinmetz Florence S. Wehr permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9139 Belvedere Dr., Frederick, MD 21704 Tammy M. Berger - Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Birdsboro Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Jan. 28, 2012 Birdsboro, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service any 5517 Vine Street, Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ advanced Senile dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown cate has been signated to page 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy performed? Yes 2 N or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my policies. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 327A RULLING Ment 30 2012 Physician/ DUSSA Medical BRITI MULE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ba Cory Timore. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Number **Funeral** Min. (Month, Day, Year) 1 - M 2 X **Director** 10d. Inside City Limits 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No GWYNN Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 1205 Martin Court Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 - Married þ Specify: Black 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education cify only highest grade completed) College (1-4 or 5+) Compani Elementary/Secondary (0-12) Person Delivery 2th grade 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name First, Middle, Last) Rollins Jimms ၉ 100-ence Andrew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elkridge Avenue /Daughter Malaika T. Jackson unden 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any injury or o Windsor Mill, MD Memorial Park 02 07 2012 4 ☐ Donation 5 ☐ Other (Specify) Vaugno C. Greene Funcial Services 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Phydallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca diac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final pression Physician/ disease or condition resulting in death) s a consequence of): Medical **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 menths?

1 Yes 2 No

9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe completely filled in by the funeral director, page 2 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No မှ 28d. Describe how injury occurred Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death Certificate: Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier (Check 29d. Date signed (Month, Day, Year) d title of certifie 29b. Signature

State Registrar 1001

Carled

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ess of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

SIMU

18. Mother's Name (First, Middle, Maiden Surname)

Physician/ Medical Examiner

Department of Health and Men Important: If item 27 is marke any injury or other traumatic

Physician/

Medical

Director

Funeral

by

Completed

Be

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10a. State

MD

17. Father's Name (First, Middle, Last)

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f sho odical Examiner must be notified at

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

page

		INK		BETSY	ZIER	-/
	19a. Informant's Name/Relationship (Type,	, Print)	19h Mailing Address (Street			
	LYNN PETTERSON/I	DAUGHTER	19b. Mailing Address (Street a 378 ENFIELD	POAD TODD	Number, City or Town, S	itate, Zip Code)
	20a. Method of Disposition			KOAD, JOPP	A, MARYLAN	D 21085
	1 X Burial 2 Cremation 3 Po	emoval from State cer	ace of Disposition (Name of metery, crematory or other plac	e) Date	20c. Location -	City or Town, State
	4 U Donation 5 U Other (Specify)	OAF	K LAWN CEMET	ERY 1/31/1	2 BALTIM	ORE, MARYLAND
	21. Signature of Funeral Service Licensee	1 1				
L	(Carried)	Tout	700 S. C	ZEILER INC	. FUNERAL	HOME
	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c	ations that caused the death.	Do not enter the mode of duine	ÖNKLING ST	.,BALTIMO	RE, MD
	Immediate Cause (Final	cause on each line.	20 Not citter the mode of dying	y, such as cardiac or respira	atory arrest,	Approximate Interval Between
	disease or condition resulting in death)	END ST	FAGE DEN	1 ENTIA		Onset and Death
		Due to (or as a consequen	nce of):	LATIA		
Į,	Sequentially list conditions, b.					
ij	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	nce of):			
an	Cause (Disease or linjury that initiated events c					
ũ	resulting in death) Last	Due to (or as a consequen	nce of):			
cal						1
edi	d					
₹	IF FEMALE:					
ian	23b. Was decedent pregnant 23c. in the past 12 months?	If yes, outcome of pregnancy	eath 3 Fotonia magazza		23d Date	e of delivery
sic	1 ☐ Yes 2 ☑ No	4 Pregnant at time of deat	th 5 Other (specify)		Mon	· ·
Ph	9 Unknown					- 47
Completed by Physician/Medical Examiner	Part II. Other significant conditions contrib	outing to death but not resulting	ng in the underlying cause give	n in Part I. 23e	Did tobacco uso contrib	oute to the cause of death?
eq						
let					1 L Yes 2 L No 3	Probably 4 Unknown
Ē				24a	. Was an 24b We	ere autopsy findings available
ပိ					performed? de	eath?
Be	25. Was case referred to medical examiner?		26 Plac	e of Death <i>(Check only one</i>	Yes 2 No 1	Yes 2 No
0	1 Yes 2 No Hospi	oital: 1 ☐ Inpatient 2 ☐ ER/0				
e	27. Manne of Death 2	28a. Date of injury 28h	Outpatient 3 - DOA	4 Nursing Home 5		
Medical Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury work?	Lou. Desc	cribe how injury occurred	
Ē	3 Suicide 6 Could not be	De Die et la constant		s 2 No		
8	4 Homicide determined 28	8e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Locar	tion (Street and Number	or Rural Route Number.
P				City	i iowri, State)	
ğ	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O	: To the best of my knowledge	e, death occured at the time, dad/or investigation, in my opinion.	ate and place, and due to t	he cause(s) and manner	as stated
	S Certifying Nurse Practice	ctioner: To the best of my kno	d/or investigation, in my opinion, owledge, death occurred at the tire	death occurred at the time, o	date and place, and due to	as stated. the cause(s) and manner stated.
-[29b. Signature and title of certifier		29c. License nu	mine place, and due	to the cause(s) and mann	er as stated.
	> San in al.	1 12 Jules			29d. Date signed (/\)	1onth, Day, Year)
ŀ	30. Name and address of parameter	1 V Juli	WIND 1) 2	1180	1-30-	12
	30. Name and address of person who comple	red cause of death (Item 23a)	Market-Pl			
:	31. Date filed (Month, Day, Year)	Julia 21	Market 1/	au Dun	dalk MI	21222
	The Date Med (Worth, Day, rear)	32. Builtrar's Signature				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Irving Charles Desmond Richards Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) 59 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year -24-1953 073-48-4675 West Indies **Director** Usual Residence of Decedent f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified Baltimore MD 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 6853 Queens Ferry Rd. 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ned Forces?

Yes 2X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Landscaping <u>Private</u> Be and Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ Ellis Richards Charles James Amabel Burnette other traumatic and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6853 Queens Ferry Rd. Baltimore, MD 21239 Chrishdel F.S. Richards/Wife Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Riverdale Park Crem. 2-6-2012 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility Ronald Taylor II FH Sonature of Duneral Service Licensee 108 W. North Ave. Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 perform Yes funeral director, 25. Was case referred to medi_ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ANO 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner -28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After atural 5 Pending Accident 1 Yes 2 No Investigation completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Paves Blvd. Balt, Md 2123 0

Registrar

State

31. Date filed (Moral)

gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26. Ruth Virginia Hickman Remmel 2012 3:30 P ^M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairhaven Retirement Community Sykesville Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Aug 22. Hours 1 □ M 2 🛭 F ^{Ye}17919 West Virginia 234-32-2393 Director 92 Usual Residence of Decedent 23a or 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Carroll Sykesville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 7200 Third Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Selina Woods Arch Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 West Obrecht Rd. Sykesville, MD 21784 Jeffrey Hickman Remmel/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remeter, crematory or other place)
Final Journey Crematory 01/30/12 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Going Home Cremation Service Beverly L. Heckrottte, P.A. (P.O. Box 784 Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner frial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No Yes 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar mai

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Haile Ramsev 27, 2012 9:27 a Jänuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Towson Baltimore Edenwald 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min April 7, 90 Director 212-20-5717 Maryland Usual Residence of Decedent shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Towson 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road 21286 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried þ Yes 2 (No If Yes, Give Year or Dates 1 Yes 2X No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 2 should be filed with h and Mental Hygien 7 is marked other tt Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Thomas Haile Burton Grace traumatic t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 E. Broadway, Bel Air, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 21014 Catherine R. Kane-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Hilltop Serv Corp 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1/31/12 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final er nd Death Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been sig 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? certificate 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral di 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work 2 🗌 No 1 Tes Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certific

State Registrar 3

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29b. Signature and title of certifie

only one

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ed (Month

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1404 TEPHEN 01 2012 8 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death)HUCK N/A Traums CENTER TIMORE . Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Days Min Hours **Director** 220-46-1106 1 🛣 M 2 🗆 F 66 01/16/1946 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Tes 2 X No BALTIMORE MD BALTIMORE 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8415 BELLONA AVENUE, #614 21204 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed WHITE Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the ADMINISTRATIVE WORKER STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 9 JOSEPH RASH DOROTHY COFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 3401 BONNIE ROAD, BALTIMORE, MD 21208 HARRIET RASH/SISTER-IN-LAW 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 01/31/2012 HAR SINAI CEMETERY OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mi 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ INTRACKANIAL EMMORHAGE disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner VEHICLE MOTOR Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami the burial-trai resulting in death) Last Due to (or as a consequence of): CERTIFIC physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the lirector, page 2 s autopsy performed' death? Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this tlit pared 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural
2 Accident 5 Pending work? 28/2012 2090DM 2 No Investigation 6 Could not be Motor Vehrelt filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined vouste within 24 hours at To the Funeral D 40 dialysis wiknows Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar 5,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Merche

31. Date filed (Month, Day, Year)

Deccesas

29d. Date signed (Month, Day, Year)

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of N	/larylan	d / Depa	artme	nt of H	lealth.	and M	ental Hy	giene			
			1 - State Registrar			Cer	tificat	e of L	Death			Reg. No	20	12	02561
	Dhuniais	/	1. Decedent's Name (First, Middle, Last)							2. Date of De	eath		/- au	3. Time of Death
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	/ 		5. Social Security Number 6. Sept	21 10 10	age (In yrs. Ia	rure of hirthday	If Unde	r 1 Year	MUM-		8. Date of Bir	+h	N/		ace (State or Foreign
- 60	Funeral Director		· ·			Yrs.	Months		Hours	Min.	(Month, Da	ay, Year)		Countr	y)
	, wo		Usual Residence of Decedent		84						02/16	/192	7		NY
	yland -f sho ed at	cto	10a. State 10b. County		10c. City	, Town or Lo								10	d. Inside City Limits
	e Mar r 28a notifi	Dire	MD N/A 10e, Street and Number			BALTI		p Code				10 0''			1 X Yes 2 No
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13	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director		12. Was Decedent	t Ever in U.S	. 13. \	Vas Dece	dent of Hi	spanic Ori	gin? (Spec	cify Yes or No-		14. Race -	America	n Indian,
300	after de	by F	1 Never Married 2 Married	Armed Forces		- 1			n, Mexicar		Rican, etc.)			White, et	c.
Rubenstein 21215-0036	urs af tural" al Exa	Completed by	3 XWidowed 4 Divorced	If Yes, Give Year or Dates.			∐ Yes	2 L A No	Specify:				Specify:	WH	ITE
35	72 ho n "nat	Jple	15. Decedent's Ed (Specify only highest grad			16a. Deced (Give	kind of wo	rk done a	ation <i>luring m</i> os	t of workin	g	16b. Ki	nd of Busi	ness/Indu	ustry
32	within giene.	Con	Elementary/Secondary (0-12)	College (1-4 or	5+)		0 NOT us M EMA I	,					OWN	HOME	
	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)			110			18. Moth	er's Name	(First, Middle,	Maiden S		110111	
/lar	d be f Venta arked	2	SAMUEL	K.	ANDELI	L			GE1	RTA_				KO	BER
Acherta Laltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	er or Rural	Route Numbe	er, City or	Town, Sta	te, Zip Cc	ode)
3 2	and 2 Health em 27 ther tr		WENDY FUHRMANECK	/DAUGHTE		•			KE W		ALTIMO			1212	
~2 or	ge 1 art of H		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ I			lace of Dispo emetery, cren	sition (Na natory or o	me of other plac	e)	D	ate	20c. Lc	ocation - C	ity or Tow	n, State
III 🥕	iit. Pa irtmer irtant injury		4 Donation 5 Other (Specify)		CAR	ROLL C							AMPSI		
Ba	Depar Impol any ir	- 3	21. Signature of Funeral Service License	Gittle		-					LEVIN				21208
			23a. Part 1. Enter the disease, or compl	ications that cause	ed the death								VILL		Approximate
1000	Physician/		shock, or heart failure. List only on- Immediate Cause (Final	4)	_{ne.} Kins	10.4	Die	seas.	0						nterval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as			01.	SEW J						-	
	Examiner	L	Sequentially list conditions,	. ———											
	7 ±	ine	if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	Due to (or as	s a consequ	ence of):									
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequ	ence of:								1	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	resulting in death) Last	Due to (or a	o a consequ	crioc oi).									
760	cate I	edic		d											
687	eath certifica attending ph for use as t	la/N	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcom	e of pregnar		1						23d. Date	of deliver	v
Вох	death e atte	sicia	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	at time of d		Ectopic Other (s)		У				Month	n E	Day Year
P.O. I	t the oby the stacks	Physician/Me	9 Unknown						-		1				
	es that the dea signed by the a I be detached I		Part II. Other significant conditions con	itributing to death	but not resu	uning in the u	naeriying	cause giv	ren in Part	I.					cause of death?
rds	require been sign	etec	- II (so nacren	VGC							-				
ဝင္ပ	has b	Completed by									24a. Was auto		24b. We	re autops or to com ath?	y findings available pletion of cause of
Ä	sician: The law r s certificate has b director, page 2 s		25. Was case referred to medical								1 Tyes			Yes 2	□ No
Division of Vital Records,	spital or Attending Physician: ours after death. reral Director: After this certific filled in by the funeral director,	To Be	evaminer?	ospital:	tiont 2 🗆 I	ER/Outpatier	+ 3 🗆 D	Othe	er.		ne 5 🗆 Resi	donos 6	Othor	Cassiful	HOSPICE
of)	g Phy er this neral o		27. Manner of Death	28a. Date of in	jury	28b. Time of		28c. Injury work			8d. Describe I		7	<i>Specify)</i>	11 051 100
on	endin sath. or: Aft he fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ay, rear)	injury	М	1 \square	Yes 2 🗆	No					
visi	l or Attendi after death, Director: A I in by the f	erti	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	njury - At hor etc. (Specify)	me, farm, stre	et, factor	y, office		2	8f. Location (City or Tov			or Rural F	loute Number,
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	Hos 24 hc Fune etely	Medical	29a. Certifier 1 1 Certifying Physic (Check 2 Medical Examin	er: On the basis of	examination	and/or invest	igation, in	my opinio	n, death o	curred at t	he time, date a	and place,	and due to	the caus	e(s) and manner stated
	To the Hospital within 24 hours a To the Funeral C completely filled	2	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: 10 t	ne best of m	y knowledge,		c. License		te and plac	e, and due to		e signed (/		
			Jolinson R	y	MD			Don.	6982	9		i _		012	
	•		30. Name and address of person who co	moleted cause of	death (Item	23a) (Type, P		,	0 1000	-		1			
<u> </u>				agivi	10 Box	(2613) , ,	SAUS	BURY	M	1)			-	
	Stat Registra	_	31. Date filed (Month, Day, Year) FFR 0 1 2012		rar's Signatu		Kad								
\/	Hegioti a		EER (L. 3. 2017)	1 /2 /2 224	41 6	. 200	LIVE								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A M 2012 6:20 Theodore Schnitz January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Briar Meadow Assisted Living Derwood Montgomery 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In vrs. last birthday) Days Months Hours Oct. 6, 1 🛛 M 2 🗆 F California Director 86 1925 382-22-7443 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5108 Granby Road 20855 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White Completed 3 X Widowed 4 Divorced and Mental Hygiene.

Is marked other than "natural" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Technician Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ၉ (Unknown) Schnitz (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Schnitz (Daughter) 19104 Clover Meadow Pl., Gaithersburg, MD 20879 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 2 Cremation 3 Removal from State Southern Cemetery Jan. 28, 2012 Donation 5 D Other (Spee Central Lake, MI 22. Name and Address of Facility
Metropolitan Funeral Service, Inc
5517 Vine Street, Alexandria, VA 22310 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical Box 68760 use as the attending p for use as s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2A No death? the Hospital or Attending Physician: hin 24 hours after death.
the Funeral Director; After this certifica To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spec Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural Accident 5 Pending 1 Yes 2 No Investigation the 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D09834 January 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragot Ave., Kensington, Maryland Barry Rosenbaum, M.D.

Registrar

DHMH 17 Rev 7/2009

State

32. Registy 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 4:37 AMM Februar <u> Charlotte Anna Schoeberlein</u> Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Center for Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 1 □ M 2 🔀 -38-6477 9/22/1940 Maryland Usual Residence of Deced 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 XNo Essex Maryland Baltimore 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral United States 21221 350 Sassafras Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Media Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Volunteer Coordinator Hospital 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wright Mary John Drogis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) <u>350 Sassafras Road</u> Essex, Maryland 21221 William Leroy Schoeberlein D.V.M. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/2/2012 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ dementio Frantotempora CKYS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter or denying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No ó Month Day Year Pregnant at time of death the z 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) \bowtie SQ 1 \bowtie 1 Yes _2 🕅 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No hours after death neral Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral I Medical -Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

31. Date filed (Month, Day, Year) 2. Registrar's Signature

S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

AARIN

6701 N. Chances

29d. Date signed (Month, Day, Year)

testus

ST TOWSON MO

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ January Year Spruil Joanne 0828 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3hadıy 6 Adventist Rockville Grove Montgomer If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Min 82 **Director** 577-36-2024 1 □ M 2 🛚 F June 8, 1929 Ohio Usual Residence of Decedent show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Gaithersburg MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20878 11908 Fernshire Rd. death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 0 barber cosmetology is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. 2 Robert Russell Mauvoreen Milligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Marcelino - daughter 11908 Fernshire Rd; Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Selicensee Ron S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ espirator disease or condition Medical resulting in death) Examiner va nc Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Yes_ 2 XNO ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 🗀 funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred i Natural 5 Pending work? 2 No hours after death. Ineral Director; A Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier January D0065505 26,2012 M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville medical Car Dr 9901 MD 31. Date filed (Month, Day Year) State Registrar

8480

D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 24 Cornea 12.10 Physician/ Month James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Cener <u>Baltimore</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min May II, Pay, Year 1914 Maryland **Director** 216-24-9211 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Baltimore Yes 2 No 10f. Zip Code 21239 10e, Street and Number 10g. Citizen of What Country? USA 1650 Woodbourne Ave; #210 Funeral be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara Lavinia Piel James Lee Wood permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ${
m un}$ 19a. Informant's Name/Relationship (Type, Print) Arthur Trump - POA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Foard Signarus of Funeral Sep 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal ueal ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) the a P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 风心o 24a. Was an page 2 s autopsy performed? certificate Yes 2 N or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 1 🗆 Yes 27 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 📈 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 2 🗌 No 24 hours after death. Funeral Director: A 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🗜 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2012 25

State Registrar 30. Name and address of berson who completed cause of death (Item 23a) (Typen Print) Truck of Baltimore of Ba

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2012 <u>Ira Roy Sewell</u> Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ralbo Memorial Easton Hospita Eastr 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Age (In vrs. last birthday) Hours (Month, Day, Year) Director 67 214-42-9732 1 🕅 M 2 🗆 F Maryland Oct 4, Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Caroline Preston MD 10e. Street and Number 10f. Zip Code ritems 23a or ner must be n 10g. Citizen of What Country? Funeral USA 21655 107 Carolin Ct. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 X No Black White etc. ō 1 Never Married 2 Married Completed by white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 0 laborer factory Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ and 2 should be Roy Vernon Sewell Iris Elizabeth Lednum traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Agnes M. Sewell - wife 107 Carlin Ct; Preston, MD 21655 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Department of Important: If 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronald S Wad 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. b. ter the diseal e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner and the burial-tran resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death
Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown eral Director; After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 은 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar mil

31. Date filed (Month, Day, Year,

12-00778
Tyler Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 0 2567 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg	No.	
Physiciar cal Examin	n/	1. Decedent's Name (First, Middle, Last) Tiler B. Smith	2. Date of Death Month January 27,	Day Year 2012	3. Time of Death 1037 hrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center 4b. City, Town, or Location of De Baltimore		4c. County of Death	
Funeral Director	0	89178 0027 JUM 2 F U Yrs. 3 7	Hrs. 8. Date of Birth	1 Foreign	hplace (State or n untry) MD
nd show any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A Boltimore			10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Direct	10e. Street and Number 10f. Zip Code 21a35		Citizen of What Cour	itry?
ter death with , or items 2.	Fune	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		14. Race - Ameri White, etc.	can Indian, Black,
36 in 72 hour han "natu lical Exan	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) O O O O O O O O O O O O O		6b. Kind of Business/l	ndustry
D 21215-0036 should be filed within 7 and Mental Hygiene, and Mental Hygiene, 7 in marked other than natic event, the Medical Tries.	8	17. Father's Name (First, Middle, Last) Som my Smith	me (First, Middle, Ma	- ,	
e, MD 21 I and 2 should I Health and Mer item 27 is mar	٦		Balto me	21225	
ages l and of Heal it: If iten other tra	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If tiern 27 injury or other traum.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	1-3-12 170 Fredhill	<u>ansdown</u> Ion Pass Bai	21229
hysician /Medical	1	23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial fell se. List only one cause on each line.	c or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Sudden Unexplained Death In Infancy Due to (or as a consequence of):	(2001)		Dodui
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
cuted md transit	EX	events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the bunial - transit	Medical	■ MENDED 23a,27,28a-f,per me,g926 4-9-1 IF FEMALE: 23c. If yes, outcome of pregnancy	12 sm	23d. Date of delivery	
Box 687/ e death certifics the attending pled for use as the		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	gnancy		ay Year
P.O. es that the iigned by t	≥	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to t	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the death of the complete of the death of the control of the death	Completed		24a. Was an autopsy perform 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
Vital Rechystian: The this certificate	නි [*]	25. Was case referred to medical examiner? 1 ✓ Yes 2 No No No No No No No	ck only one) sing Home 5 Re	esidence 6 Other	
nding Ph. th. r: After tl e funeral	으 : : :	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred	
Divisior Divisior Septral or Attend hours after death meral Director: y filled in by the i	E	2 Accident 3 Suicide 6 Could not be determined (Specify) 4 Homicide Homicide 1 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: Residence	28f. Location (Stroor Town, State Brooklyn	eet and Number or Ru e841 Clinty MD.	al Route Number, City
To the Hosp within 24 hc To the Fun completely i	<u>ا</u> ق	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated			
e Williams	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		9d. Date signed <i>(Mon</i> January 28, 2012	
sona		30. Name and address of person who completed cause of death (Iten∮23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	e, MD 21223		
Stat	ta i	31. Date filed (Month; Day Year) 32. Registrar's Signature		OCI	AE

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4115 am CAROLYN NORMA SIGISMONDI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death JOSEPH RICHEY HOUSE BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days **Director** 212-26-2114 1 🗆 M 2 🗶 F 82 NOV. 12,1929 MARYLAND Usual Residence of Decedent 28a-f show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD N/A BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 709 S. ELLWOOD AVENUE 21224 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married by If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Completed 3 X Widowed 4 Divorced Specify: WHITE the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) HOUSEWIFE DOMESTIC is marked other Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be **EDGAR** CORNELL DORIS CAREW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 27 JANET SIGISMONDI/DAUGHTER 9903 LANDS RD., APT. 10, MIDDLE RIVER, MD other 1 Important: If item any injury or other Baltimore, 3 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ģ 1 ☐ Burial 2X Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 2/1/12 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. ician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by thoulation 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a, Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? performed? 1 Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Hospice 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be within 24 hours after death To the Funeral Director: 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗆 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

MJ-Rinus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02569 State of Maryland / Department of Health and Mental Hygiene

and openion		Registrar	te of Death	Reg. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day You Danuary 27, 2012	3. Time of Death ear 1540 hrs
cal Exami	ner	Travis Spencer 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
		Sinai Hospital	Baltimore	4c. County	i/A
Funeral Director		5. Social Security Number 219-15-5755 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	- 0 /0 /0 ~	→ 9. Birthplace (State or Forei → Country) → Country) → Country → Co
¥		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location		10d. Inside City Limits
Maryland 28a-f show any d at once.	tor	MD N/A Ba	altimore	I 40a Citizen of V	1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 1210 Cochran Ave	10f. Zip Code 21239	10g. Citizen of V	
fter death witl I", or items 2 ier must be n	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Pates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year Or Dates:	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: 		ce - American Indian, Black, pite, etc. CICan Amer.
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I tant: If item 27 is marked other than "natural", or items 23a or 28a-f abt or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation (Give kind of w ring most of working life, DO NOT use retir Forklifter		Business/Industry 10use
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hyggiene. In 27 is marked other than numatic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Thurman Spencer		(First, Middle, Maiden Surnam I Denise Bra	
T 3 2 3 5 1	2	19a. Informant's Name/Relationship (Type, Print) Mother Darnell Denise Braxton/ 1	Mailing Address (Street and Number or R 210 Cochran Ave,	Balt.,MD 212	239
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumatic		A Division of Commettee of Removed from State cremator	ity cem.	3/12 Balt.	
Salti ermit. epartn mports		21. Signalure of Funeral Service Licensee	22. Name and Address of FacilitHar 5126 Belair Rd,	i P. Close I Balt. MD 212	206-5105
		23a. Part I. Enter the disease, or complications that caused the death. Do not			neart Approximate Interval
³hysician /Medical		failure. List only one cause on each line.			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUNDS (2) OF IOTSO Due to (or as a consequence of):			
	Ļ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause			
Si d isi	Xar	events resulting in death) Last Due to (or as a consequence of):			
760, crate be executed by physician and the burial - transit	ca	d. UNPENDED AMENDED			
60, ate be e shysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date	of delivery
1876 rtifical ing ph as the	an/N	23b. Was decedent pregnant in the nest 12 months?	Fetal death 3 Ectopic pregna		
Box 687 e death certific the attending p	sici	4 Pregnant at time of death 5	Other (Specify)		
that the death certifined by the attending detached for use as 1	Physician/	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use cor	ntribute to the cause of death?
P.C. res that signed 1 be deta	by			1 Yes 2 No	3 Probably 4 Unknown
ords, F w requires to been sign should be	etec			24a. Was an 24b	Were autopsy findings available prior to completion of cause of
e law e has t	Completed			performed?	death? 1 Yes 2 No
Vital Rec ysician: The linis certificate		25. Was case referred to medical	26.Place of Death (Check		
Vita ysicia his cer direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	tpatient 3 DOA Other Nursin	g Home 5 Residence 6	Other:
ision of Vi Attending Physi r death. ector: After this by the funeral dir	n: To	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. T	ime of Injury 28c. Injury at Work?	28d. Describe how injury occi Subject shot	urred
Sion Attendi death. cctor: A	atio	2 Accident Investigation	1 165 2 4 116		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safe death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, far	m, street, factory, office building, etc.	28f. Location (Street and Nun or Town, State) 2700 West Coldspring Lar	mber or Rural Route Number, City
Hospi 4 hou Funer ely fil		4 Homicide 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place, and	I due to the cause(s) and manr	ner as stated.
To the I within 2 To the I complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)
		10/11/11/1	O.C.M.E.	January :	28, 2012
2		30. Name and address of person who completed cause of death (Item/23a)			
3		Zabiullah Ali, M.D. Assistant Medical Examiner 900) W. Baltimore Street, Baltimore,	MD 21223	
	tatie	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		OCME
Regis	ueu	FEB 0 1 2012 Januar & park			

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital

nours after death neral Director: A filled in by the f 24 hours a To the I within 2

	Part II. Other significant conditions conf	tributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did	tobacco use contribute to the cause of death?					
				1 🗆	Yes 2 No 3 Probably 4 Unknown					
and in a				_ per	s an opsy formed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
	25. Was case referred to medical		26. Place of Death (Check only one)							
2	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify)						
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	work?	28d. Describe	how injury occurred					
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office		(Street and Number or Rural Route Number, wn, State)					
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)								

D72527

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

04:23 AM

Maryland

1 🗌 Yes 2 🙀 No

10d. Inside City Limits

Onset and Death

Day

JANUARY 25 2012

21201

Year

Birthplace (State or Foreign Country)

White

Registrar DHMH 17 Rev 06-2011

State

GREENE ST.

MN

S,

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phelan, MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Norma Claudine Stroup Jan 29, 2012 9:56 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Somerford Place Assisted Living 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗷 Months Hours 314-18-8265 89 Yrs Jun 16, 1922 Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits MD Howard Columbia 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8220 Snowden River Parkway U.S.A. 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Yes 2 M No If Yes, Give (Year or Dates. Black, White, etc. 1 Never Married 2 Married 2 No 1 Yes White Specify: 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 **Administrative Assistant** Clerical 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Claude G. Gilbert Cecil M. Burklo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolland Stroup, Jr. Son 88 Emily's Pintail Dr. Bridgeville, DE 19933 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Burlai 2 Cremation 3 Removal from State I.O.O.F. Cemetery Feb 03, 2012 Montpelier, IN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused e.g. h line. 23a, Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of) Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

Completed by Funeral

Be

2

Examiner

Funeral

Director

notified

28a-f

9

permit. Page 1 and 2 should be filed within 72 hours after death be pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

items 23a or ner must be r

with the Maryland

attending physician and for use as the burial-tran signed by the a page 2 should been this certificate has completed filled in by the funeral director, Medical Certificate: 24 hours after death. Funeral Director: After

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

Completed by

Be မ

29b. Signature and title of certifier

Name and address of person who complet

0

FEB

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1				23d. Date of delivery Month Day Year		
Chronic Obstructive Kulmonary Disease					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown		
conferme Have sachere				24a. Was an autopsy performed?		able e of	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one)						
	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	3	
	286 Place of Injuny - At home form street tactory office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ysician: To the best of my know				and manner as stated.	r stated	

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 2 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 11:00 AM STRAWSE 0 20/2 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgon REhab EMANYON. Murding Kensing Aer Birthplace State or Foreign Country) UNK 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 1 🗆 M 2 🖭 Months Min. 216-74-8875 90 Sept **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Kensington Montgomery 10f. Zip Code 20895 10g. Citizen of What Country? 3000 McComas Avenue Completed by Funeral Was Decedent Ever in U.S. unk
 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status unk Black, White, etc. white 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 McComas Avenue; Kensington, MD 20895 19a. Informant's Name/Relationship (Type, Print) Kensington Nursing & Rehab injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Ronald 655 W. Baltimore St; Baltimore, MD 21201 wi art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or he art failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 🗌 No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 10 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 🗌 Yes 2 🗷 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 25/

State Registrar KENSINGTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

INGTON

FEB 0 1 2012

Dav. Year)

31. Date filed (Month

2012

MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day9 2012 January 1:40 Рм James William Schwarz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 6902B Mornington Rd. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year, 58 **Director** 218-62-3524 1 🛣 M 2 🗆 F Jan 12, 1954 Maryland Usual Residence of Decede and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 6902 B Morning Road USA · death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Was Deceden.. Armed Forces? → Yes 2 X No Black, White, etc 1 X Never Married 2 Married þ Maryland 21215-0036 filed within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental fitem 27 is marked ည John Tennyson Schwarz Elizabeth Helen Bartholomew injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Perry Oak Place; Baltimore, MD 21236 John Schwarz - brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or of once. Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Spec y) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Lorangry disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to incredible cause. Enter Underlying Exami Iding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant Unknown Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, adendarcinoma 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 📉 No 24a. Was an autopsy performed? 1 Yes 2 No has page 2 • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate I 2 XNo Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural Certificate: 28d. Describe how injury occurred injury 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Bev 06-2011

State

Hopkins Hospital

Bottoncore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 28, 2012 **ESTHER** 2:13 TURPIN A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CALVERT MEMORIAL HOSPITAL CALVERT FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Hours MARCH 16, 577-90-4846 GERMANY Director 49 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ust be notified 1 X Yes 2 No MARYLAND CALVERT HUNTINGTOWN 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3255 EVANS ROAD 20639 UNITED STATES items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. "natural" 3 Widowed 4 Divorced Specify: Completed **BLACK** event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACT MANAGER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever 2 LAWRENCE MATTHEW GRAY, RUTH JR. WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3255 EVANS ROAD, HUNTINGTOWN, JOHN TURPIN / HUSBAND MARYLAND 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Department of Important: If any injury or RIVERDALE CREMATORY 1/31/2012 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD, HYATTSVILLE, MD 20785 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failt Immediate Gause (Fil al ailure. List only one cause on each line. Onset and Death Physician/ disease or condition resulting in death) Medical Du to r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the a g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown should ! 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 P No ပ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 25 PM Jacqueline Loretta Timpson Medical JANUFIE 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CET SINAL HOSPITAL OF BALTIMORE 5. Social Security Number 218-62-5449 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 1 □ M 2 😾 F Yrs. 60 Usual Residence of Decedent 01/15/1952 Maryland show 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Baltimore N/A MD 0 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3000 Reisterstown Rd. 21215 .S 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 1 Tes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) year Nursing Assistant Nursing Home marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Timpson Irene Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Charles Wilson(friend) 3000 Reisterstown Rd., or other Baltimore, MD21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 02/02/12 |Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Faility Joseph n. Brown Jr. Funeral Home PA arqueter Fulton Ave., Baltimore, MD21217 Mart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Iternia disease or condition cerebral Medical resulting in death) Examiner Edemo Cerebral Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine the burial-transi Cause (Disease or injury that initiated events Fschemic cerebral Vascular Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death g ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records. 1 Yes 2 No 3 Probably 4 Unknown Completed HYPEV+ENS:ON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes MELLETUS TYPE I 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1
Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day. Year) Kathr RES OOC January 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w. Brivedave KATHLEEN OKTAVEC MD. SINAIHOSPITAL OF BALTIMORE BALTIMOVE MOZIZIK

DHMH 17 Rev 06-2011

State Registrar filed (Month, Day, Year) FEB 0 1 201

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 hon bnuary Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 10 WSO 2 11 more 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral Social Security Number Min. Hours 1 M 2 F Months Davs (Vrs Director Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Nes 2 No 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 2120 death v or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No þ 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical Decedent's Usual Decupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) House eeper Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 1 Kel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) altimore 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State Memorial 4 Domation 5 Other (Spenty) 21 Signature of Funeral Service cense any KLD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastalic Fibrogascoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Hriknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ 25. Was case referred to medical 26. Place of Death (Check only one) Be ျှ 1 \sum Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 27. Manner of Death 28d. Describe how injury occurred 5 Pending iniury 1 Watural 2 🗆 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and t e of cer D71020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 2 CHARL APATHT KUMA 31. Date filed (Month, Day, Year) Pagistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death edent's Name (First, Middle, Jast) 3. Time of Death Month Son Physician/ 1:77 DM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Hea Mes If Under 1 Year 7. Age (In vrs. last birthday, If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 F Months Davs 220 2a Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 ☐ No γD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 Ellicott 115A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗷 No Specify: Black If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) eacher Be 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) Balto. Mo ilson 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) cemetery, crematory or other place) remator atons Ville, MD 12 21229 Balto mo hilton Hass 23a. Part VEnter the resease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or 📥 a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical NI SON FOULTHED Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 01855101 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examina? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) death (Item 23a) (Type, Print) 30. Name and address of person who complete

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:15A M WILLETTE D. WHITE 01-30-2012 Medical 4a. Facility Name (if not institution, give street and number)
5807 PIMLICO ROAD 4b. City. Town, or Location of Death **Examiner** 4c. County of Death BATTMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours 220-03-9836 **Director** 1 🗆 M 2 🔀 F 91 Yrs. 03-19-1920 WASHINGTON D.C Usual Residence of Decedent 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 0 MD BATIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Funeral 5807 PIMLICO ROAD 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: and Mental Hygiene. is marked other than "natural", Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) INDEPENDENT LPN Be Maryland 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev-once. 2 Q MIDGETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD BATIMORE, MD . 21209 5807 PIMULES SUTTON (PAUGHTER) SONDRA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BATIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHT GREENE FUNERAL SCVS PA 21. Signature of Funeral Service Licens ROAD. M1636 4905 BACTIMORE, MO-21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, i i.n. (ongestive disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Commary years Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 🎛 Probably 4 ☐ Unknown Completed Vascular Diseas Keripheral 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed VASCULAR DISCOSO Cerebral 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNO 1 Inpatient 2 FER/Outpatient 3 IDOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: A: 1 Yes 2 No 2 Accident Investigation Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) John F. Maria mD D2 5025 Jan 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F., MARRA MD 5601 Loch Raven Blvd State Registrar

DHMH 17 Rev 06-2011

			_ FOI	partment of Health and Mental Fertificate of Death	Hygiene Reg. No. 2012 02579
		76	Decedent's Name (First, Middle, Last)	2. Date of Month	
	Physici /Medio		Clayton Williams	janra	my 28 2012 990 PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
7			Bon Secour 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Baltimore // If Under 1 Year If Under 24 Hrs. 8. Date of	N/A Birth 9. Birthplace (State or Foreign
	Funeral Director		244-02-8972 12M 2 F 55 Yrs.	Months Days Hours Min (Month	Day Year) Country) 05/1956 N. Carolina
	P.		Usual Residence of Decedent		
	anylar ehow	_	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 1 ☑Yes 2 ☑-No
	he M	ecto	MD N/A	Baltimore	10g. Citizen of What Country?
	with	급	2501 W. Lombard St.	10f. Zip Code 21223	U.S.A.
-	death with the Maryland me 23s or 28s-f ehow finust be notified at	era		. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9	or Ital	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc., 1 Yes 2 No Specify:	
5-0036	hours after tural', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Black
15-	n 72 h	Completed	(Specify only highest grade completed) (Given the completed)	edent's Usual Occupation se kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry Peterson
2121	filed within Hygiene. other than "	omp	Elementary/Secondary (0-12) College (1-4or 5+)	hine Operator	Aluminum
	illed Hygin other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	ddle, Maiden Sumame)
/lar	should be nd Mental marked o	To B	Elijah Evans	Jessie Lee	Williams
Maryland	and land is ma	·		ling Address (Street and Number or Rural Route Nu	
	1 and Health tem 27 other tr		Maxicene V. Williams(wife) 250 20a. Method of Disposition 20b. Place of Disp		altimore, MD 21223 20c. Location - City or Town, State
Baltimore	of of or		1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr	emetory or other place)	
i	permit. Pag Department Important: any Injury o		' 4 □ Donation 5 □ Other (Specify) IVYHil 21. Signature of Funeral Service □censee	1 Cem. 02/11/12	Medoc, NC
Ba	Depa Impo any l		Man Dan	Joseph H. Brown Jr. 2140 N. Fulton Ave.,	Funeral Home PA Baltimore, MD21217
N			23a. Pan1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition	day to perturale	Onset and Death
	¹ /Medical Examiner		resulting in death) Due to (or as a consequence of):		
4, 8	LAGITITIE	<u>_</u>	Sequentially list conditions, b. Supply (2000)	la,	
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that instead green in a cause)	lune/Concer	
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):		
09289	cate be executed obysician and the burial-transit	call	End Stude	Kenal Jalusc	
99	nifica ng ph as th		IF FEMALE:		
Box	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant 1 2c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy	23d. Date of delivery Month Day Year
0.	the a	yslc	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)	
Δ.	that the ded by detact	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. (Did tobacco use contribute to the cause of death?
Records,	puires n sign ald be	Completed by	Hypertension		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown
000	law require as been si 2 should b	olete	Aenatilia C.		Was an 24b. Were autopsy findings available
Re	The lav	mo	make (mell, to	a g	autopsy prior to completion of cause of death? es 2 1 Yo 1 Yes 2 No
Vital	stan: artifica ctor, p	ВеС	25. Was case referred to medical examiner?	26. Place of Death (Check or	
of V	Physician: this certificatal director, I	2	1 ☐ Yes 2 1 1 6 Hospital: 1 Impatient 2 ☐ ER/Outpati		Residence 6 Other (Specify)
on C	After After funera	lon:	27. Manner of Death 1	of 28c. Injury at 28d. Descr Work? M 1 ☐ Yes 2 ☐ No	ribe how injury occurred
Division	Attending r death. actor: Atter	ficat	2 Accident investigation 3 Suicide 6 Could not be determined contained. 28e. Place of Injury - At home, farm, s	street, factory, office 28f, Location	on (Street and Number or Rural Route Number,
Div	al or safter	Certification:	4 Homicide determined building, etc. (Specify)	City or	r Town, State)
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, december 2 Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
1	To t To t	Σ	29b. Signature and title of certifier	29c. License number D 0034730	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type 250 W. Shift More 5to ex	- Boltmoe MD &	91993
	Sta Registr		31. Date Hieg (Month, Day, Year) 32. Registrar's Signature FEB 0 1 2012 Server A. January	,	
		_	•		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 16, 9:40 A M 2012 NANCY EDITH SHUHART ATKINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT 11398 ST. JAMES NEWTOWN ROAD WORTON If Under 1 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💢 Days Hours Min 01/15/1938 NEW JERSEY Yrs. **Director** 148-28-5504 74 Usual Residence of Decedent 28a-f show äţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD KENT WORTON o 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 11398 ST. JAMES NEWTOWN ROAD 21678 UNITED STATES items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No "natural", or i Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) FOOD AND BEVERAGE 12 FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev HARRY C. SHUHART VIVIAN STEELE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11398 ST. JAMES NEWTOWN ROAD WORTON, MD 21678 GARY ATKINSON / SON Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 01/20/2012 CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 30 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death - Physician/ METHSTATIC CATALLUMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Ordenying Cause (Disease or iinjury Due to (or as a consequence of) Examir and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Į Month Day 5 Other (specify) Pregnant at time of death detached the P.O. ģ been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 2 🗆 No certificate Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending n 24 hours after death.

The Funeral Director: After pleted filled in by the fur 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital Medical 29a. Certifier ertifying Physician: To the this tof my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basil of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one

State Registrar

DHMH 17 Rev 7/2009

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29b. Signatu

Name and address of perso

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Then us 122 Stern RD 5785 CHESTENTOWN MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year **Physician** JAN 12 6:15 A M CARROLL EUGENE BENNETT /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MONTGOMERY 18711 WASCHE ROAD DICKERSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/10/1929 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours MD 82 Director 215-26-0507 Usual Residence of Deceden 10d. Inside City Limits 10c City Town or Location 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evergine rust or notified at 1 ☐ Yes 2 No Director MONTGOMERY DICKERSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 20842 18711 WASCHE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1951 -14. Race - American Indian Black, White, etc. 72 hours after 1 Dever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1953 Specify Specify: WHITE ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 72 th and Mental Hygiene.
7 Is marked other than "n. NIH ANIMAL Elementary/Secondary (0-12) College (1-4or 5+) POWER PLANT ENGINEER CENTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FEDORA L. THOMPSON GLENN W. BENNETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traumonce. DAVID BENNETT / SON 2515 OLD COACH CT., FREDERICK, MD 21702 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKLAWN CEMETERY 01/16/2012 ROCKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensi 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner TOBACCO USE UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) signed by the a 1 □Yes 2 □No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ✓ Yes 2 No 3 Probably 4 Unknown DIABETES, SLEEP APNEA s peen s Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate HYPERCHOLESTEROLEMIA 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation spital or Attendi nours after death. neral Director: A death. 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Poolesville 19710 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 10:55 PM Elaine Lucille Bunting Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 10/27/1948 MD 1 □ M 2 🛣 F **Director** 63 20-46-8348 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov ital Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 1 Yes 2X No Forest Hill Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21050 331 Ponfield Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1X Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: If Yes. Give white Completed 3 Divorced 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher/Librarian 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eventonce. 17. Father's Name (First, Middle, Last) Evelyn Hudson မ William T. Bunting 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10231 Golf Course Rd., Ocean City, MD 21842 Charles L. Bunting/bother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/21/12 Berlin, MD Other (Specify) Buckingham Cem. 4 Donation 5 22. Name and Address of Facility Burbage Funeral Home Service Licens 108 William St., Berlin, MD 21811 Justa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final BRUZCAC Ply i jan/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical i or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 **N**o မ 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No Matural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 00058475 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOWATRIEN, STOUPPER CHTISAPILANT DIZIE, BILLAR MO ZICIY DH 10 PATUEP 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		•	For State Registrar	State	of Marylan		artment of F tificate of L	lealth and N Death	Mental Hy	giene _{Reg. No.} 2 (12	02583
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	g. Births	place (State or Foreign
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Baltimore,	ge 1 au nt of H : If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal fro	m State	emetery, crem	sition (Name of natory or other plac	e)	Date	20c. Location	•	
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VITA	ysicia is cert directi	To Be	examiner? 1 ☐ Yes 2 🂢 No	Hospital:	Inpatient 2 🛣	ER/Outpatien	100	ace of Death (Checer: 4 Nursing Ho		dence 6 Oti	ner (Specify	
0	ffer th		27. Manner of Death 1 ↑ Natural 5 □ Pendin	28a. Dat	e of injury onth, Day, Year)	28b. Time of injury	28c. Injury work	/ at		now injury occur		
VISION OF	death ctor: A the fi	Certificate:	2 Accident Investig	ation not be	ce of Injury - At ho	ome farm stre		Yes 2 No	204 Leastier (Street and Numi	an an Dunal	Paula Alumahan
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-	to the brophial or Attending Frigstoals. The law requires that the bearth centilizate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E	xaminer: On the ba	asis of examination	n and/or invest	igation, in my opinio	date and place, ar on, death occurred a	t the time, date a	and place, and d	ue to the cau	use(s) and manner stated.
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State of Maryland / Department of Health and Mental Hygien 2 1

02584 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:05 P.M Brooks January 14, Cecelia 2012 Marie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons Nursing Center Solomons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/17/1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2\ F Yrs. Maryland 213-42-8308 67 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "netural", or Iteme 23e or 28e-f show the Medical Example or must be colified at 1 ☐ Yes 2 ☑ No Director Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number U.S.A. 125 German Chapel Road 20678 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 accounts payable specialist construction and Mental Hygir 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 Is markad oth any jury or other treumatic event 2008: 17. Father's Name (First, Middle, Last) Be George Ernest Bowen Susie Minnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pauline S. Quade, P.R. P.O. Box 1107, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 01/22/2012 Alexandria, VA 21. Signature of Funeral Service Licensée 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 yan 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Meto Static /Medical Due to (or as a consequence of) Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ut as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Dunknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate or Attending Physicien: After this certification funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٤ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier Jan 17, 2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 5 Noble PriNe Fred 238 Merrimac (Saymon 32. Registra s Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

19 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3:401 M 2012 Roward Nevil Bell JANUAR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctors Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months Days Hours 1 🛣 M 2 🗆 F 1-12-1947 579-58-9936 Washington DC Director 64 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 28a-f 1X Yes 2 No Prince George's Bladensburg Md 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō must be Funeral USA 20710 4207 54th place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status er than "natural", or iter the Medical Examiner Armed Forces?
1

XYes 2 □ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Construction Fork Lift OPerator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha ည Thomas Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4207 54th Place Bladensburg Maryland 20710 Patricia Bell, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 prematio 1-20-2012 Bladensburg Maryland Ft Lincoln Cenetery 4 Donation 22. Name and Address of Facility Royald M Taylorll Fureal Home 21. Signature of 10583 Middleport Lane White Plains Maryland 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Non Small Cell Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Bilateral Preuronia Sequentially list conditions, if any, leading to immediate cause. Enter crossnying Examiner Due to (or as a consequence of) Chronic Costructive Lung Disease Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Preumo Thorax P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death ed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Be Completed by 1 Tes 2 No 3 Probably 4X Unknown Division of Vital Records, Pleural Effusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia has e 2 autopsy performe 1 ☐ Yes 2 🗶 No 1 🗌 Yes 2 🗌 No Leukocytosis 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other: 1 X Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify, 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🕇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Abebe, MD

State Registrar Amare

31. Date filed (Month, Day, Year)

JAN 1 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amare Abebe, MD 8118 Good Luck Rd Lanham Maryland 20706-3596

DHMH 17 Rev 7/2009

D0052557

12-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		4	For State Registrar	State of ivi		ertificate of D			g. No.	
	Physicia	n/	Decedent's Name (First, Middent)	1 1 /1			2	2. Date of Death Month	Day Year	3. Time of Death O
	Medic	al	Lora Eliza 4a. Facility Name (if not institution		ryman	4b. City, Town, or I	Location of Death	Month	14 2012 4c. County of Death	0919 M
	Examin	CI	Garrett Coun		spital	Oaklan			GARRETI	
	Funeral Director		5. Social Security Number 216-22-5905	6. Sex 7. Ago	e (In yrs. last birthday 85 Yrs.	Months Davs	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, You 05/25/	ear) Count	lace (State or Foreign ry) Land
	nd ihow at	ا ا	Usual Residence of Decedent 10a. State 10b. Coun		10c. City, Town or	Location			1	0d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Gar	rett	Oak	land				1 Yes 2 No
	with the s 23a or 2	Funeral Di	10e. Street and Number 50 Mews Cres	cent Dr. Ai	ot#7	10f. Zip Code	1550	10	g. Citizen of What Coun	try?
936	within 72 hours after death with the Maryland glene. eg than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 🔀 M 3 ☐ Widowed 4 ☐ Divorce	12. Was Decedent E Armed Forces? 1 Yes 2	Ever in U.S. 13	3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🏋 No		fy Yes or No- can, etc.)	14. Race - America Black, White, e Specify: Wh	
Maryland 21215-0036	2 hours "natur	plete		lent's Education hest grade completed)	I (Giv	cedent's Usual Occupa ve kind of work done do	ation uring most of working	7 1	6b. Kind of Business Inc	lustry
121	within 7. giene. ner than t, the Me	Com	Elementary/Seconday (0-12))+)	.DONOT use retired) :gal Secre	etary		Law Fir	m
nd	lled v Hyg othe	Be c	17. Father's Name (First, Middle				18. Mother's Name (iden Surname) Pugh	
ryla	ould be fi d Menta marked matic ev	2	William F 19a. Informant's Name/Relation	Bell	405 14	-ili- n A dalance /Ctroot o	Thelma	E.	ity or Town, State, Zip C	ode)
	f and 2 should be f Health and Men item 27 is marke other traumatic		H. Howard (Husb 50	Mews Cr	escent D	r. Apt	7, Oaklan	dMD 21550
Baltimore,	o = 5 o		20a. Method of Disposition 1 ☐ Burial 2 🂢 Crematic 4 ☐ Donation 5 ☐ Other	n 3 Removal from State (Specify)	Crema		1/15	/12	0c. Location - City or To	le, PA
Ball	permit. Page Department Important: any injury conce.		21. Signature of Funeral Service	Mathen	lan	203 S. S	econd St	., Oak	neral Hom land, MD	es P.A. 21550
				or complications that aused t only one cause on each line	ne death. Do not e e.	h	g, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
~	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence of):	Conges	THE WE	23~7	fs: mg	71397
	Examiner	_	Sequentially list conditions,	b. ———		Hyp	er fen	150		negn
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a consequence of).	('				
	icate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
09/	physic the bu	Medical		d						
. Box 687	ath certific attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mounts? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death	3	у		23d. Date of delive Month	ery Day Year
s, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant cond	tions contributing to death b	out not resulting in th	ne underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to the	
Division of Vital Records,	aw requi as been 2 shouk	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
Re	sician; The la certificate ha irector, page 2							perform		2 🗆 No
/ital	ysician is certif director	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital	ient 2 ER/Outpa	Othe	er: 4 Nursing Hom		nce 6 Other (Specify)
of	iding Phys th. After this funeral di		27. Manner of Death	28a. Date of inju	ury 28b. Time	e of 28c. Injury y work	/ at 28	8d. Describe how		,
sion	Attendii death. ctor: At y the fu	Certificate	2 Accident Inve	stigation	ury - At home, farm,	M 1 -	Yes 2 □ No 2	8f. Location (Stre	eet and Number or Rura	Route Number,
Divi	Hospital or Attending 24 hours after death. Funeral Director: After sted filled in by the fune		4 Homicide dete	building, et				City or Town,	State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completed filled in by the fi	Medical	(Check 2 Medica	ing Physician: To the best of Il Examiner: On the basis of e ing Nurse Practioner: To the	examination and/or in	vestigation, in my opinio	on, death occurred at t	he time, date and	I place, and due to the ca	use(s) and manner stated.
_	To the Comp		29b. Signature and title of certi	ier		29c. License	number	29	d. Date signed (Month,	Day, Year)
	•		30. Name and address of person	on who completed cause of	death (Item 23a) (Typ	e, Print)	2277		11111	~
		5	Dr. Thomas	Johnson 3	11 N. Fo	urth St.,	, oakland	d, MD 2	21550	
	Sta Registr		31. Date filed (Month, Day, Year JAN 1		rar's Signature	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-00619 State of Maryland / Department of Health and Mental Hygiene 2012 02587 Brenn Monet Carter Certificate of Death 1. For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 22, 2012 1745 hrs Brenn Carter Monet Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Fredrick Calvert Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Months Days Hours Director Country) MD 09/11/1993 218-39-3801 1 M 18 2X F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 1 Yes 2 XNo MD Calvert Huntingtown 28a-f show death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2245 Smoky Road 20639 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes Biracial 5 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Š 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 the Medical **Baltimore, MD 21215-0036** Never Worked N/A 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) DeFeo Carter, III Crystal Robert Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2245 Smoky Rd. Huntingtown, MD 20639 Robert M. Carter,III/father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition 1 x Burial 2 Cremation 3 Removal from State crematory or other place) 1/28/2012 Brentwood, MD t. Lincoln Cem. Donation 5 Other Specify: 6 22. Name and Address of Facility Sewell Funeral Home, 21. Signature of Funeral Service Licenses 1451 Dares Bch.Rd. Prince Fred., MD20678 lader 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease a Multiple Injuries Ėxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and or use as the burial - tran AMENDED 23a,27,28a-f,per me,g925 3-1-12 sm Physician/Medical X UNPENDED of Vital Records, P.O. Box 68760, 23d. Date of deliven 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year Day Live birth 2 Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ੬ Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗹 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, examiner? Other Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After within 24 hours after deam.

To the Funeral Director: A 1 Natural driver fixed object collision Division 1 Yes 2x No 5 Pending fd 1631 hrs fd 1-22-12 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2953 Dalrumple Rd. Sunderland, MD. determined (Specify) roadway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Régistrar's Signature

and manner stated.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Zabiullah Ali, M.D.

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARI 705 AM 15 2012 B Catlett Vivian Medical 4c. County of Death Prince Georges 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 02/17/1917 578-36-2937 94 **Director** 1 □ M 2 🛣 F Maryland Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Lanham Prince Georges 28a-f Maryland Y Yes 2 No o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country's Funeral "natural", or items 23a 9313 Lanham Severn Rd 20706 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates and Mental Hygiene.
Is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) St. Elizabeths Elementary/Secondary (0-12) College (1-4 or 5+) Hydro Therapist 12 Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matthew P. Lucas Jennie J. Davis 19a. Informant's Name/Relationship (Type, Print) Hermin Rowe (Daughter) 19b Mailing Address (Street and Nymber or Rural Route Number City or Town, State Zip Code) 1607 Pebble Beach Dr. Mitchellville, MD 20721 Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Mem Cemetery 01/21/2012 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of neral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 Part 1. Enter the disease, o shock, or heart failure. List polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ongestive PERIF disease or condition Medical resulting in death) **Examiner** ricel -15 Cill Cetion Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the at d be detached for 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending
Investigation work? 1 ☐ Yes 2 ☐ No Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hor To the Fune completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 06-2011

8118 GOODWCK

32. Registrar's Signature

LANHAM, MARYLAND 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BISHAN

8

31. Date filed (Month, Day, Year)

		1 _ State	of Maryland / I	Department of I Certificate of I			20	12 02589
4		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of t	Dealii	2. Date of Death		3. Time of Death
Physic Med		Arnie L.	Calhoun,	Jr.		J ^{Month} January	16, 201°	
Exam	iner	4a. Facility Name (if not institution, give street and nun 4413 Ridgecrest Drive	nber)	4b. City, Town, o	r Location of Death		4c. County of I	
Funera		Social Security Number 6. Sex	7. Age (In yrs, last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g	George's . Birthplace (State or Foreign
Directo		295-18-4922 1XM2□F	88	Yrs. Months Days	Hours Min.	(Month, Day,) 03/20/1	.923	Ohio
and show	٥	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
Maryls 28a-f	irect	Maryland Prince George'	s Suit	land				1 🗆 Yes 2 🍱 No
ith the 3a or t be n		10e. Street and Number 4413 Ridgecrest Drive		10f. Zip Code	20746	10	g. Citizen of Wha	
eath w tems 2	Funeral Director	11. Marital Status 12. Was Dece	edent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spe	cify Yes or No-	USA 14. Race - /	American Indian,
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ed by F	1 ☐ Never Married 2 ☐ Married Armed Fo XX Yes 3XXWidowed 4 ☐ Divorced If Yes, Giv.	ve WW TT	If Yes, specify Cuba	an, Mexican, Puerto I	Rican, etc.)		White, etc. White
15-0 72 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of working	ng 1	6b. Kind of Busin	ess/Industry
vithin / jiene.	Con	Elementary/Secondary (0-12) College (1 4 year		life. DO NOT use retired) Accounting		F	ederal G	Government
nd : filed v tal Hyg d othe	To Be	17. Father's Name (First, Middle, Last)	•	<u> </u>	18. Mother's Name	(First, Middle, Ma	aiden Surname)	
Ore, Marylal 1 and 2 should be of Health and Ment fitem 27 is marker rother traumatic		Arnie L. Calhou			Dixie		wers	
- 04 = 04 £		Cathleen C. Johnson / Da	T	. Mailing Address (Street)7 Oak Hill			-	1
Baltimore, bernit. Page 1 and Department of Heal Important: If item: any injury or other		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from	20b. Place of	f Disposition (Name of ry, crematory or other place	ce)	ate 2	0c. Location - Cit	
Baltimor permit. Page 1 Department of Important: If it any injury or once.		4 Donation 5 Other (Specify)	Otate	gton Nat. Ce	2/3/2			n, Virginia
Departit. Departit. Importa		21. Signature of uneral Sergice Licensee) ,	6160 0xon	Hill Rd.	Oxon Hi	11, Mary	eral Home PA Land 20745
		23a. Part M. Enter the disease, or complications that a shock, or heart failure. List only one cause on ear Immediate Cause (Final	caused the death. Do nach line.	not enter the mode of dyin	ng, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
⊸Ph _y sician Medica		disease or condition	chasta (or as a consequence of	Hc lun	g car	cer		Oriset and Death
Examine		Sequentially list conditions, b.	MAN	1 astes	ie di	cease	2	
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of	to cenou	8	eere		
executed an and rial-transi	Exal	that initiated events c.	(or as a consequence of		u aa	recce	<u> </u>	
	edical	d						
certificate be nding physiciuse as the bu	/Me	IF FEMALE: 23c. If yes, out	come of pregnancy					
BOX death of the attention and for us	Physician/M	in the past 12 months? 1 Live 4 Preg	Birth 2 Fetal death nant at time of death	3 Ectopic pregnand 5 Other (specify)	су		23d. Date o Month	f delivery Day Year
that the d	Phys	9 ☐ Unknown 9 ☐ Unkn				1		
S, F, F, resthatisismes signed doe do	d by	Part II. Other significant conditions contributing to d	eath but not resulting i	n the underlying cause gr	ven in Part I.			te to the cause of death?
Ordina v requires been s been s shoul	Completed					24a. Was an	24b. Wer	e autopsy findings available
HeC The lay ate has	Som					autopsy perform	ed? deat	r to completion of cause of th? Yes 2 \sum No
Ital ician: certific rector,	Be	25. Was case referred to medical examiner?		26. Pl	lace of Death (Check	only one)	-	
g Physer this eral di	e: To	27. Manner of Death 28a. Date		itpatient 3 L DOA 28c. Injur	y at 2	me 5 Resider	ice 6 Other (S	Specify)
eath. or: Afte	ficat	2 Accident Investigation	th, Day, Year) ii	njury	k? Yes 2 No			
DIVISION OT VITAI HECONAS, tal or Attending Physician: The law requires is after death. Jinector. After this certificate has been sig ed in by the funeral director, page 2 should b	Certificate:		of Injury - At home, fai ng, etc. (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
DIVISION OF VITAL RECORDS, P.O. BOX 68/7 To the Hospital or Attending Physician: The law requires that the death certificuthin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check Certifying Physician: To the base of the description of of	est of my knowledge,	death occurred at the time	e, date and place, an	d due to the caus	e(s) and manner a	as stated.
the H thin 24 the Fu	Mec	only one) 3 L Certifying Nurse Practitioner	sis of examination and/o	wledge, death occurred at t	the time, date and pla	ce, and due to the	cause(s) and mann	ner as stated.
111		29b. Signature and title of certifier		29c. Licens	e number 065816	1	d. Date signed (M	ionth, Day, Year)
is vit		30. Name and address of person who completed caus	se of death (Item 23a) (Type, Print) Uchech	_		<u>Juriuc</u>	x 4 11,2012
		5801 Allentown	Road	cang	_ '	gs W		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	W		3 .		and the state of t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dawson Leroy 2012 10:28 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany 18923 High St. Barton 6. Sex 7. Age (In vrs. last birthdav f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-10-5275 Days Hours (Month, Day, 94 **Director** 1**X** M 2 □ F Maryland May 15 1917 28a-f show 10b. County 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director MD Allegany Barton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 21521 Funeral 18923 High St. items 23a United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status was becedent Ever in 0.5.

Armed Forces?

1 ★ Yes 2 □ No ₩ 2

If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 Specify: white 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than entary/Secondary (0-12) Tire Manufacturer College (1-4 or 5+) and Mental Hygiene. is marked other tha Loader unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Dawson Rennie Shuhart permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e traumatic 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Jean Darlene Kooken/niece 14313 Greenfield Cres, Cumberland, Maryland 21502 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Laurel Hill Cemetery 1 Burial 2 Cremation 3 Removal from State 01/25/2012 Barton, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility Boal Funeral Home · a de 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ OFFICIE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions cause. Enter Underlying Examine to for as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last executed burial-trar Due to (or as a consequence of) physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as guipt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Pregnant at time of death Month Day Year 5 Other (specify) the, P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page performe certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No ပ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After

Tipletely filled in by the funer Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29a. Certifier (Check

only one)

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

30. Name and address of person who

within To the

death (Item 23a) (Type, Prin)

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d, Date signed (Month, Day, Year)

21502

29c. License number

🚜 Certifying Nurse Practitionef: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Kenneth Raymond Durst 2012 1516 01 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany egional Medical Center umberlang Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) If Unde Months **Funeral** 213-40-2763 Director 1 🗶 M 2 🗆 F August 14, 1940 Maryland 71 10d. Inside City Limits 28a-f show 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes 2 X No Grantsville Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21536 USA 1751 Lower New Germany Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 😧 No Specify: Yes Give Specify: White 3 Widowed 4 Divorced Completed oe filed with.
Mental Hygiene.
-ad other than "natu.
-t, the Medical Ey Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Agent & Appraiser Real Estate other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed n and Mental I Cordella Garlitz Raymond Durst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1735 Lower New Germany Rd., Grantsville, MD 21536 Page 1 and 2 s ment of Health s ant: If item 27 i Helen G. Oester/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of fmportant: If it any injury or o 1 💆 Burial 2 🗌 Cremation 3 🗌 Removal from State Jan. 25, 2012 Grantsville, MD Trinity Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Serving $\forall \forall$ P.O. Box 275, Grantsville, MD 21536 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and De 23a. Part 1. Enter Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 U Other (specify) 1 ☐ Yes ∠ L g ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 has performed' 2 🗷 No 1 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 IDOA ပ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 🗌 No Investigation Accident 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Nurse Practitioner: To the best of my Mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Certifying 29b. Signature and title of certifier 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 Willowbrook Rd., Cumberland, MD 21502 Qamar Zaman, M.D.,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2

		4	State of Maryland	/ Depa	artment d tificate d	of Healt	h and M		South	012	02592
			1. Decedent's Name (First, Middle, Last)	Cer	tificate c	or Death	7	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		BERTHA LOUISE ELBORN					Month JANUAF	Day	2012	6:15 A ^M
	Medic Examin	_	4a. Facility Name (if not institution, give street and number)		4b. City, Tow	n, or Location	on of Death	0111101		inty of Death	
	LXdIIIII	Ŭ.	25667 WEST HILL ROAD		WORTON	ī			KEN'	Γ	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) 51 Yrs.	If Under 1 Y Months D	rear If Und lays Hour		8. Date of Birt (Month, Day 12/19/1		Cour	place (State or Foreign ntry) YLAND
		1	Usual Residence of Decedent)1				12/15/1		IIII	
	shov d at	ģ	10a. State 10b. County 10c. City,	Town or Loc	cation						10d. Inside City Limits
	Mary 28a-f otifie	Director	MARYLAND KENT WORTO)N							1 Yes 2 XNo
	th the	<u>a</u>	10e. Street and Number		10f. Zip Co					of What Cou	
	ms 2 mus	Funeral	25667 WEST HILL ROAD 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	21678 Was Decedent		Origin? (Spec	ify Yes or No-		D STAT	
0	or ite	by Fi	1 Never Married 2 Married 1 Yes 2 No	It	f Yes, specify	Cuban, Mex	ican, Puerto F	tican, etc.)		Black, White,	
3	rs afte ural", Exar		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	I□Yes 2 🛚	No Spec	cify:		Spe	cify: WHI	TE
<u>ဂ</u>	2 hou "natu	plet	15. Decedent's Education (Specify only highest grade completed)	(Give F	dent's Usual O kind of work d	one during n	nost of workin	g	16b. Kind o	of Business Ir	ndustry
121	within 72 hours after death with the Maryland jiene. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner.	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	DISAI	O NOT use ret RT.FD	tired)			N/A		
N.	be filed within 72 hours after death with the Maryland anta Hygiene. Ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 25a or 28a-f sho c event, the Medical Examiner must be notified at	Be (0 17. Father's Name (First, Middle, Last)	DIOM	<u> БЫББ</u>	18. M	lother's Name	(First, Middle,		ame)	
an	ould be filed w nd Mental Hygi marked other matic event, t	욘	UNKNOWN			UNK	NOWN				
Baltımore, Maryland 21215-0036	2 should be th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (St	treet and Nu	mber or Rural	Route Numbe	r, City or Tow	n, State, Zip	Code)
Σ	and 2 s Health i tem 27 i		MARGARET LIVELY / CASE WORKER				CHESTE	RTOWN,			
ore O	e 1 and 2 t of Healt If item 2 or other		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, cren	sition (Name of matory or othe	r place)		ate		ion - City or T	
Ē	t. Page tment o tant: If jury or		4 Donation 5 Other (Specify)		CEMETE			/2012			I, MARYLAND
Rai	permit. Page 1 Department of Important: If it any injury or c		21. Signature of Funeral Service Licensee		ELLOWS 30 SPE	HELE HELE ER ROA	ENBEIN D CHES	& NEW	NAM FU N, MAR	NERAL YLAND	HOME, P.A. 21620
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~. J	Physician/	C 93	Immediate Cause (Final disease or condition	ry F	adunt	•				75	Onset and Death
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	be executed sician and burial-transit	Exa	that initiated events c. Due to (or as a conseque	nce of):				· · · · · · · · · · · · · · · · · · ·			
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9289	ifficate ng phy as th	Med	IF FEMALE:								
9 ×	th cert tendir or use	Physician/Me	23b. Was decedent pregnant 1 Live Birth 2 Fetal	death 3	Ectopic pre				23d	I. Date of deli Month	ivery Day Year
Вох	e deat the at hed fo	ysic	1 Yes 2 No 9 Unknown	ath 5 L	Other (spec	ity)			1		
P.O.	at the		Part II. Other significant conditions contributing to death but not result	ting in the ι	underlying cau	se given in f	Part I.	23e. Did t	obacco use	contribute to	the cause of death?
	ires the signer of signer of the signer of t	Completed by	Mental Returdation, Bipolur Disor	rde/	Lysly	oiden	iu,	1 🗆	Yes 2 🗆 I	No 3 🗆 Pr	robably 4 Unknown
ord	requipeen shoul	ete	Tur hy Arahvania	,				24a. Was		4b. Were aut	topsy findings available completion of cause of
ě	he law te has age 2	l iii	1000 1100 1100		_			auto perfo	primed?	death?	
a F	an: T	BeC	25. Was case referred to pedical examiner?			26. Place of	Death (Check				
₹	nyslci nis ce I direc	<u> </u>	1 Yes 2 No 1 Inpatient 2 E				Nursing Ho	/ 2		Other (Speci	ify)
0	fter th	ate:	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28a. Date of Month, Day, Year)	28b. Time o injury	-	. Injury at work?	_	28d. Describe I	how injury oc	curred	
Ö	tendi death tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ne form et	M reet factory o	1 🗆 Yes		28f Location (Street and No	umber or Rui	ral Route Number,
Division of Vital Records,	l or Ai after Direc	Se	4 Homicide determined building, etc. (Specify)	ie, iaim, su	reet, lactory, o	MIGG		City or To	vn, State)	arriber or rier	arriodic ramson,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier Certifying Physician: To the best of my knowle	dge, death	occured at the	e time, date	and place, an	d due to the ca	ause(s) and m	nanner as sta	ated.
	he Ho in 24 l	Med	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	and/or inves knowledge,	stigation, in my death occurre	opinion, dea dat the time,	th occurred at date and plac	the time, date e, and due to the	and place, an ne cause(s) ar	d due to the o	stated.
	Vith To th		29b. Signature and title of certifier •		29c. L	icense numb	per	0	29d. Date s	igned (Month	n, Day, Year)
			NO MIC			bdo	430	8	1-1	8.01	017
			30. Name and address of person who completed cause of death (Item:	23a) (Type	Print) PL	h.B	Mod	porto.	nH	02	1620
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire _	1	da		na iw	-1 1 1		
	Registr		JAN 1 8 2012	B. A	Marie Contract						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 1155 Month Physician/ 2013 0 Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washing 14516 inch ane Hancock 9. Birthplace State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country 219-14-9427 1 🗓 M 2 🗆 F Director 88 Yrs. MD 08/20/1923 Usual Residence of Deced items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No MD Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 21750 14516 Finch Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n 11. Marital Status Armed Forces:

1 X Yes 2 If Yes, Give
Year or Dates. Black White, etc. þ 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed and Mental Hygiene.

Is marked other than "natur 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aircraft Manufacture Assembler 6 Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Hallie Jane Corbett John Everett traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 21750 14516 Finch Lane Hancock, MD George M. Everett, Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 01/28/2012 Big Pool, MD 4 Donation 5 Other (Specify) Parkhead Cemetery 21. Sign ture of uneral Sawa 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 Approximate Interval Between Onset and Death inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or co shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 1500 avd disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events and I-tran Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the hur Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autops perform 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Son's home examiner? Other: 4 Nursing Home 5 Residence Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA 2 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: iniury work? 1 ☐ Yes 2 ☐ No 1. Natural 5 \square Pending Investigation □ Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Decrtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

only one 29b. Signature and title

FEB 0 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Barbara A. Spencer 747 Northern Avenue Hagerstown MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 I 2012 January 12:36 Robert Paul Fronzaglio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Days Hours Min (Month, Day, Year) Director 70 Yrs 61-32-1960 1★ M 2 □ F Jan 8, 1942 Pennsylvania or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Mt. Airy Maryland Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıl Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be Funeral 21771 USA 4231 Bartholows Road Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 2X No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Communications Cable splicer technician event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked of Ir other traumatic ever မ Clarinda Biasini Joseph Frank Fronzaglio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau once. 21771 4231 Bartholows Road, Mt. Airy, Maryland Wanda Fronzaglio - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Pleasant Hill Cemetery 1-14-2012 Monrovia, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sign / re of Funeral Service Licensee Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Genevieve Frances Frazee 2112 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Cumberland Allegany Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours **Director** 213-84-6137 1 M 2 X F 84 May 13, 1927 Pennsylvania 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No MD Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14167 Friendsville Rd. 21531 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 K Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Completed 3 Widowed 4 Divorced White al Hygiene. d other than "natura event, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Farming Dairy 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William J. Harbaugh Daisy Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne R. Frazee/Husband 14167 Friendsville Rd., Friendsville, MD 21531 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Asher Glade Cemetery Jan. 21, 2012 Friendsville, MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. There he disease, of complications that caused shock, or healt failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause Final disease or condition Onset and Death Ph_sician/ avanoma Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month Year Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 No death? 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 injury 5 Pending Accident Investigation after death 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) DO0 33280 2011 Jan

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta, 625 Ken Ave., Cumberland, MD

32. Registrar's Signature

31. Date filed (Month, Day Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ January 15, 2012 11:25 AM Edna F. Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville Goodwill Mennonite Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F Nov. 8 1922 Pennsylvania 89 **Director** 193-18-0974 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 X Yes 2 No Salisbury PA Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 15558 USA 70 Grant St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene
Important: If item 27 is marked
any injury or other **-(Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Textiles Presser Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Sarah E. Hutzell Lewis C. Broadwater 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 90 Calaboone Rd., Doylestown, OH 44230 Judy K. Hutzell/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Jan. 18, 2012 Salisbury, PA Salisbury Cemetery 4 Donation 5 Other (Specify) Newman Funeral Homes, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death n signed by the at Id be detached fo 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY 2 No 1 Yes 3 Probably 4 Unknown should s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.

E Funeral Director: After this certificate has been are director, page 2? autopsy performed? perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the the only one 29b. Signature 29d. Date signed (Month, Day, Year) 2 January 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 Miller St., Grantsville, MD 21536 Robin Bissell, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02597 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13 Year 1:00/N Medical Facility Name (if not institution, give street and number dity Town, or Location of Death Gounty of Death **Examiner** Wer1 Week 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🗆 M 2 🖳 Months Hours Min 71 **Director** 230-48-1395 2/14/1940 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 □ No MD Caroline Federalsburg 10e. Street and Number 10g. Citizen of What Country? 9 10f. Zip Code Funeral 23a 904 Garden Court 21632 items ; 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ō Completed by 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black "natural", 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Laborer Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard John Savage Sue Esther Smith permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Savage/Daughter Interfaith Ave. Federalsburg, MD 21632 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/20/12 1 Burial 2 Cremation 3 Removal from State injury or Federalsburg, MD 4 Donation 5 Other (Specify) Federal Hill Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home any 855 ST Chestertown High 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC PANS Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ law requires 1 Tes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 D Other (Specify) Hague Core 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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Congreville

CONTREVILLE

2540

VILLAS

JAN 18

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 124, 2012 8:20 AM Dolores Franco Figueroa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Bradford Oaks Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 134-22-7488 Director 1 🗆 M 2 🗶 F 89 April 5, 1922 Puerto Rico Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland all Hygiene.

J other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at went, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Prince George's Fort Washington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 USA 4511 LuJean Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Buerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Rican Specify: Hispanic 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Catholic Charities Caregiver permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nicolasa Lopez Pablo Franco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Cooley - Daughter 7313 Riverhill Rd., Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Edgewater, MD 1/20/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A 6160 Oxon Hill Rd., Oxon Hill, MD. 20745 21. Signatury of Juneral Service Licenses 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final - Ph_, sician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Other (specify) Pregnant at time of death Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide work?
1 Yes 2 No 5 Pending Investigation 24 hours after deatr Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 7 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print)

Registrar

12-00557 Paige Ford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ige Ford		1- For State Registrar	State of Maryland	•	rtment of He tificate of De		ntai Hyg		20 l eg. No.	2 0259
Physicia edical Exami	an/	Decedent's Name (First, Manage Paige	Monique		Ford			Date of Deat Month January 20		3. Time of Death 0632 hrs
			tution, give street and number)			ty, Town, or Location			4c. County of De	ath
Funeral		5. Social Security Number	•	e (in yrs. la	st birthday) If l	Inder 1 Year If Un		8. Date of Birt	th (MM/DD/YYYY) 9. I	
Director		215-71-2787	1 M 2 🔭	7	Yrs.	onths Days Hou	ırs Min.	Nov 9	, 2004	eign CountryMD
7 any		Usual Residence of Decedent 10a. State 10b. Cour		10c. City,	Town or Location					10d. Inside City Limits
ryland a-f shov t once.	ctor	MD 10e. Street and Number	Allegany		Cumbe	erland Zip Code		10	Og. Citizen of What Co	1 X Yes 2 No
the Ma 3a or 28	Director	309 E. Har	rison Street			21	1502		U	SA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mernal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Esaminer must be notified at once.	Funeral		Married 12. Was Decedent Armed Forces? 1 Yes 2 Divorced If Yes, Give Year		If Yes, sp	edent of Hispanic Or ecify Cuban, Mexica 2 X No specify	an, Puerto R		White, etc.	erican Indian, Black, Black Tite
nours aft	Completed by	15. Decedent's Education (Lor Dates: Specify only highest grade com		16a. Decedent's Us	ual Occupation (Give working life, DO NO	e kind of wo		16b. Kind of Busines	s/Industry
136 thin 72 h	nplet	Elementary/Secondary (0-	12) College (1-4 or 5	5+)	student			,	school	
15-0(filed wi al Hygier ed other t, the M		17. Father's Name (First, Mid			<u> </u>	18,Mothe			Maiden Surname)	
212 nould be nd Menta is mark	To Be	Jymar Fo	onship (Type, Print)	ther	19b. Mailing Addr	ess (Street and Nu urnace St	umber or Rui		ery nber, City or Town, Sta Imberland	nte, Zip Code) MD 21502
and 2 st lealth an		Jymar Ford 20a. Method of Disposition		20b. P	lace of Disposition (Name of cemetery,		Date	20c. Location - City	
MOre Pages 1 rent of H		1 Bunal 2 Crema 4 Bonation 5 Qthe	_	210	rematory or other pla set Memoria			1/25/2012	Cumber	land MD
Balti permit. Departu Import injury		21. Sign ture of Funeral Sen	rice Licensee		22. Name	and Address of Facil Scarpelli Fu	uneral Ho			
Physician /Medicai		23a. Par I. Enter the disease fail re. List only one car	or complications that caused use on each line.	the death.	Do not enter the mo	108 Virginia de of dying, such as	a Avenue cardiac or n	espiratory arre	rland MD 215(est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final dise or condition resulting in death				mal Injuries				Death
	-6	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):					
<u> </u>	Examine	cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La	ed C.	equence of)	:					
50, te be executed sysician and burial - transit	ie E	UNPENDED	d	nor f	h c027 5-	2_12 cm				
'60, ate be er ohysiciar	Medical	IF FEMALE:	23c. If yes, outcom			2-12 511			23d. Date of delive	ery
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and optietely filled in by the funeral director, page 2 should be detached for use as the burial – transit	Physician/A	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ■	unknown 1 Live birth 4 Pregnant at 9 Unknown		2 Fetal de		pic pregnanc		Month	Day Year
P.O. Ess that the gned by the detachec	by Ph	Part II. Other significant cor	nditions contributing to death	but not re	sulting in the underly	ying cause given in F	Part I.		bacco use contribute	to the cause of death?
ds, Prequires t	eted							24a. Was a	an 24b. Were	autopsy findings available
of Vital Records, ig Physician: The law requir ther this certificate has been sineral director, page 2 should t	Completed							autops perfor 1 Yes	med? death'	completion of cause of Yes 2 No
ital Redicion: The s certificate irector, page	a	25. Was case referred to med examiner?	fical Hospital: 1 Inpatie	nt 2 🗸	ER/Outpatient 3	26.Place of Deatl			Residence 6 Ott	ner:
of V ing Phys After thi uneral d	1: T	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		28b. Time of Injury 0605 hrs	28c. Injury at Wo	rk? 28	Bd. Describe h	now injury occurred m of accidental I	
Division tal or Attendir rs after death. al Director: A led in by the fu	icatio	2 Accident Ir	ovestigation 28e Place of Ini		me, farm, street, fac	1 Yes 2 tory, office building,	∠ No			Rural Route Number, City
Division ospital or Attend hours after death uneral Director:	Certification:	4 Homicide	etermined (Specify) Sin	gle Fam	ily Home		30	or Town, Si 9 Harrison S	tate) Street, Cumberland	, MD
To the Hospita within 24 hours To the Funera completely fills	Medical	(Orlock Only	g Physician: To the best of my Examiner: On the basis of examiner and manner stated.							
	ž	29b. Signature and title of cer				29c. License numbe	er		29d. Date signed (A	
OCME		30. Name and address of per	son who completed cause of de	eath (Item :	23a)	O.C.M.E.			January 21, 20	14
		Mary G. Ripple MD	Deputy Chief Medic	cal Exam	iner 900 W.	Baltimore Stree	et, Baltimo	ore, MD 21	223	
St Regist	ate	31. Date filed (Month, Day, Ye	32. Registrar	Solgnatur	arked					

DHMH 17 Rev 1/2001 OCME 2006

			State of Marylar	nd / Depa	artment of H tificate of D	lealth and	d Mental Hy	giene 201	2 02600
			1. Decedent's Name (First, Middle, Last)	Cer	lilicate of L	reauri	2. Date of De	Reg. No.	3. Time of Death
	Physicia		Harriett Perry Gartner				Januar	Day Yea	
in	Medic Examin	-	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of D	
			Montgomery Village Health Care		Montgome			Montgo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 1 1 M 2 K) F		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	ıy, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent 94	Yrs.			March	6, 1917 M	laryland
	yland f sho	tor		ty, Town or Lo	cation				10d. Inside City Limits
:	e Mar 28a- notifie	Director	Maryland Montgomery I 10e. Street and Number)amascu					1 Yes 2 No
	/ith th	rall	5 Clearwater Court		10f. Zip Code 2087	72		10g. Citizen of What U.S.A.	Country?
	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U	S. 13. V	Vas Decedent of His	spanic Origin? (Specify Yes or No-	14. Race - A	merican Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant if firem 27 is marked other than "naturalr, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Vegr or Dates	i i	Yes, specify Cubar		erto Rican, etc.)	Black, W Specify: V	
21215-0036	nours natura cal E	Completed	Year or Dates. 15. Decedent's Education	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busine	
215	in 72 h e. nan "n Medi	dmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give I	kind of work done d O NOT use retired)	luring most of w	rorking		
2	ygiene ygiene her th	Be Co	12	Ho	memaker			Own Hon	ne
Maryland	or filed intal H ced of ced of	To B	17. Father's Name (First, Middle, Last)				lame <i>(First, Middl</i> e, nn ie Ben		
ary.	ould but the mark	·	Harry Perry 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	a Address (Street a			er, City or Town, State,	Zip Code)
Ĕ	d 2 sh alth au 1 27 is ertrau		William H. Perry - Son	1	,			, Maryland	
ore,	of He of He if item r othe				sition (Name of natory or other place	e)	Date	20c. Location - City	or Town, State
altimore,	: Page tment tant: I			ytonsv	ille Ceme	etery 1			lle, Maryland
Bal	Depart Impor any in	3	21. Signature of Funeral Service tipensee		Name and Addres olesworth 6401 Ridg	s of Facility i-Willia ge Road,	ams P.A., Damascu	Funeral H	lome ad 20872
П			23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of dying	g, such as cardi	ac or respiratory ar	rrest,	Approximate Interval Between
P	hysician	j j	Immediate Cause (Final disease or condition resulting in death) a. Aspiration		nia				Onset and Death Hours
	Medical Examiner		Due to (or as a consec	quence of):					37
	100	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	juence oij.					Years
1	nd ransit	Examiner	Cause (Disease or injury that initiated events Peripheral		Insuffi	cency			Years
	is that the death centificate be executed igned by the attending physician and be detached for use as the burial-transit	al E)	resulting in death) Last Due to (or as a consec	quence of):					
209	physic physic the b	edical	d						
89	nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregn		1			23d. Date of	delivery
Box 68	deatri le atte ed for	Physician/M	in the past 12 months? 1		Other (specify)	:y		Month	Day Year
0	of the etach		9 Unknown Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I	220 Did t	ahacca usa contribute	e to the cause of death?
Division of Vital Records, P.O.	signed of be d	d by							Probably X Unknown
ord	v requ	Completed					24a. Was		autopsy findings available
Sec	ne lav te has vage 2	om					 auto perfo 1 □ Yes 	ormed? death	to completion of cause of n? Yes 2 □ No
e .	ertifica ctor, p	Be C	25. Was case referred to medical examiner?			ace of Death (Cl		2210,	
5	nysio	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐			4 A Nursing		dence 6 Other (Sp	pecify)
n oi	aing r h. After t funer	Certificate:	27. Manner of Death 1 🔀 Natural 5 🗆 Pending 2 🗀 Accident Investigation	28b. Time of injury	work	≀at ? Yes 2 □ No	28d. Describe l	how injury occurred	
Sio	Atten ir deat ector: by the	rtifi	3 Suicide 6 Could not be 28e. Place of Injury - At h	ome, farm, str				Street and Number or	Rural Route Number,
≥ O	tal or rs afte al Dira led in		4 - Horniciae acterminea building, etc. (Speci.	'y)			City or Tov	vn, State)	
	To the thospital of Attending Priysician; The law requires that the death centificate de executed within 24 hours after death. To the Funeral Directors After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination of the basis of the basis of examination of the basis of	on and/or invest	tigation, in my opinio	on, death occurre	ed at the time, date a	and place, and due to ti	he cause(s) and manner stated.
-	within To the Sompl	Σ	only one) 3 Certifying Nurse Practitioner: To the best of 29b. Signature and title of certifier	my knowleage,	29c. License		o prace, and due to	29d. Date signed (Mo	
			> & Alautanel A		D313	91		January 1	7, 2012
	10		30. Name and address of person who completed cause of death (Ite						
			Suhair H. Abulfarag, M.D. 6 31. Date filed (Month, Pay, Year) 32. Registrar's Sign.			Ave.,	Gaithers	ourg, Md.	20877
	Stat Registra		JAN 1 7 2012 32. registrars sign	p. A	rarked				

amend #25, per me, g928 6-15-12 sm Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5AA Physician/ 08:45 M KAREN GILL 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDILAL (PUTE) OF MARYUND BALTIMORE UNIVERSITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Feb 1, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 106-76-4904 **Director** 1 🗆 M 2 🕱 F 40 Guyana, S.A. Usual Residence of Decedent f show 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 U.S.A. 212 Ashford Court Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. sart. If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Assistant Health Care Department of Health and Mental Hygiei Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carl Orrett Gill Sr Stella Angela Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Karen Lango, PR/Guardian 2001 Burnside Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Mt Olivet Cemetery Jan 21, 201**2** Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fuheral Service L censee Signatu 22 Keeney & Bastord P.A. Funeral Home 106 E Church St, Frederick, Maryland 0 >M00706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final BREAST CANCER METASTATIC Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICA Hospital or Attending Physician: The law requires that the death certificate be executed eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Kidney injury 2 No 3 Probably 4 Unknown Methicilla Resistat Stephylococcus avneus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 X Yes 1 Anpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending 24 hours after death. Funeral Director: At Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of confife 29c. License number 29d. Date signed (Month, Day, Year) MD - PHYSICIAN 24346 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O 12. South Greene St. BALTIMORE, MD 21201 CARISTOLHER KOLTZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 17 Registrar

		1	State		epartment of H Certificate of D			iene _{eg. No.} 20	112	02602
	D 1		Registrar 1. Decedent's Name (First, Middle, Last)				Date of Deat Month	h	Year	3. Time of Death
er a	Physicia Medic	al	Edith E. Gaines 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	ocation of Death	January	15 201	L2	7:45A M
	Examin	er '	Collingswood Nursing Home			ckville			ntgome	ry
	Funeral			e (In yrs. last birthda	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Country	
	Director		071-32-7986 1 □ M 2 ☒ F Usual Residence of Decedent	72 _{Yrs}			July 26	1939		York
	yland f shov ed at	ctor	10a. State 10b. County	10c. City, Town or					100	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ne Mar or 28a- notifi	Director	MD Montgomery 10e. Street and Number	De	erwood 10f. Zip Code			I0g. Citizen of \	What Countr	
	with the s 23a c ust be	Funeral	6704 Heatherford Court			0855		Unite	ed Sta	ites
920	within 72 hours after death with the Mayland glene. glene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☒ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, et Whi	c.
2-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occupa Bive kind of work done d	ation uring most of work	ing	16b. Kind of B	usiness/Indu	ustry
21215-0036	l within 7 /glene. her than t, the Me	Completed	Elementary/Secondary (0-12) College (1-4 or 4	5+)	e. DO NOT use retired) Journalis	t		News	paper	
þ	filed v al Hyg 1 othe vent,	To Be	17. Father's Name (First, Middle, Last) Arthur Gaines	•		18. Mother's Nam Edith		Maiden Surnam	e)	
Maryland	at and 2 should be fill of Health and Mental filtem 27 is marked or other traumatic ever		19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street a	nd Number or Rura	al Route Number,	City or Town, S	State, Zip Co	ode)
	nd 2 sh ealth a m 27 is ner tra		Ruth G. Hepner / Sister		04 Heatherf			od, Man		
nore	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	Disposition (Name of crematory or other place olitan Crem	e)	6/12			Virginia
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	netrop	22. Name and Address P.O. Box	s of Facility Mu		Barber	Funer	al Home
		П	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	d the death. Do not						Approximate Interval Between
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mod	Medical Examiner			a consequence of	: scular Dise	ease				
		iner	Favuratially list conditions D.	a consequence of)						
	ate be executed bhysician and the burial-transit	Examiner	Cause (Disease or injury	a consequence of)	:					
09	s be ex /sician e buria	dical	d							
9289	rtificate ting physe as the	Med	IF FEMALE: 23c. If yes, outcom-	of pregnancy				204.5	-t- of dollars	
Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and arial director, page 2 should be detached for use as the burial-transi	Completed by Physician/Me	236. Was decedent pregnant 1 Live Birth	2 Fetal death at time of death	3	ey			ate of delive	ry Day Year
ls, P.O.	requires that the been signed by should be deta	ed by P	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause gi	ven in Part I.				e cause of death?
Division of Vital Records,	The law requi ate has been page 2 shoul	Complet					24a. Was autor perfo 1 Yes	SV	. Were autop prior to cor death? 1 Yes	esy findings available inpletion of cause of
ital	sician; certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	tient 2 - ER/Out	Oth	er:	ome 5 Resid	lanca 6 🗆 Ot	har (Specifil)	
of V	g Physter this neral d	te: To	27. Manner of Death 28a. Date of in	jury 28b. Tir	me of 28c. Injur	y at	28d. Describe h		-	
ion	or Attending after death. Director: After in by the fune	Certificate:	2 Accident Investigation		M 1 C	Yes 2 □ No	28f. Location (S	Street and Numi	ber or Rural	Route Number,
Sivis	al or At s after or I Direct d in by	Cer	4 Homicide determined building, 6	etc. (Specify)	n, street, ractory, onles	V	City or Tow			
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of Only one) 3 Certifying Nurse Practitioner: To	examination and/or	investigation in my opini	on death occurred :	at the time, date a	ind blace, and d	ue to the cat	ise(s) and manner stated.
	To th within To th comp	-	29b. Signature and the of certifier		29c. Licens			29d. Date sign	ed (Month, L	
	3	-	30. Mame and address of person who completed cause of M. Rita Ghosh, M.D. 1481	death (Item 23a) (To	ype, Print) ians Lane,	#161, Ro	ckville,	MD 20	0850	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	Janes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ rnol 13 2013 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Inton Inton Georges and chah Funeral 1 Year If Under 24 8. Date of Birth 9. Birthplace (State of Foreign 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year) Maine Director 005-32-0928 78 anuary Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2X No Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9111 Bank Street 20613 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Navy 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 N Widowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) 1 and 2 should be filed withing thealth and Mental Hygiene item 27 is marked other thother traumatic event, the Welder <u>Self Employed</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl W. Glidden Ida Ham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to David Glidden/Son Garner Avenue, Waldorf, Maryland 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sanford, Maine unknown Oakdale Cemetery Signature of Funeral Service Lifensee 22. Name and Address of Facility Huntt Funeral Home MØII9Ø 3035 Old Washington Rd. Waldorf, MD. 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line, ediate Cause (Final ase or condition Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate 1 Yes 2 No ₁ ☐ Yes 2 000 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No 4 hours after death uneral Director: / Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 2012 0006982 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY Day, Year) JAN 19

Registrar

				Please 1	Type or Print in	Black Indelil	ole Ink. Ensure	All Copie	s Are I	Legible.	
			For		State of Marylan	d / Departme	nt of Health and	Mental Hy	giene		
			StateRegistrar			Certifica	te of Death		Reg. No.	2012	02601
	Physicia	n/	1. Decedent's Name	e (First, Middle, Last)		(+ 0 - 7 -	-403	2. Date of De Month	. # Day	Year	3. Time of Death
	Medic	al	MAI	HMOUL		GORJII	7	01		2012	0100 AM
	Examin	Ĭ.	SHADY	not institution, give st	ADVENTIS	TR	y, Town, or Location of Death	=	1		GOMERY
	Funeral Director		5. Social Security No. 578 - 66. Usual Residence of	-3148 ix	7. Age (In yrs. In	Ast birthday) If Und Months	er 1 Year I If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Cou	nplace (State or Foreign ntry)
	and show lat	ō	10a. State	10b. County	10c. Cit	y, Town or Location			3 1 / 5		10d. Inside City Limits
	Maryla 28a-f	rect	MD	MONTG	OMERY R	ROCKVIL	LE		_		1 Yes 2 No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. To is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Num 604 No			10f. 2	ip Code 20850		_	en of What Cou	untry?
	death items ier m	핊	11. Marital Status		12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puert	pecify Yes or No-	- 14	4. Race - Amer	
5-0036	ırs after o ural", or I Examin	ted by	1 ☐ Never Marri 3 ☐ Widowed	ied 2 XMarried 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates.		2 No Specify:	or nour, oto.,	Sį	Black, White	
5-(72 hou "natu edica	ple	(Spe	15. Decedent's Edu cify only highest grad			ork done during most of wor	king	16b. Kind	d of Business/I	ndustry
	should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the M	e Completed	Elementary/Seco		College (1-4 or 5+)	life. DO NOT u ENG	INEER				RICAL
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ē,	of Health of Health fitem 27 rother tr		20a. Method of Disp	position	20b. F	Place of Disposition (N	ame of	Date	20c. Loc	ation - City or	Town, State
E O				☐ Cremation 3 ☐ F 5 ☐ Other (Specify)	Removal from State	FIRDAUS	MEM CI	15/2/2	FRE	EDER	ICK MD.
Baltimore	permit. Page Department Important: I any injury o	1	21. Signature of Fur	neral Service License		22. Name	and Address of Facility	DENM	USLI	MFUI	NERAL SEA
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п			shock, or hear	rt failure. List only one				or respiratory a	rrest,		Approximate Interval Between
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68760	ertifica ding p	/We	IF FEMALE:	2	3c. If yes, outcome of pregna	ancy					
Вох	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death certificate be the Funeral Director: After this certificate has been signed by the attending physici mpletely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	23b. Was decedent in the past 12 t 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live Birth 2 Fet. 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi				3d. Date of del Month	Day Year
P.O.	es that the dea signed by the a be detached i	y Ph	Part II. Other signif	ficant conditions con	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
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Records,	w requires s been sig 2 should b	Completed						24a. Was		24b. Were aut	opsy findings available
3ec	The law te has bage 2	mo			-31			perf	opsy formed? 2 1 No	death?	2 No
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of Vital	Physic this ce	은	1 ☐ Yes 2 🖸	NO .		ER/Outpatient 3		Home 5 Res	idence 6	Other (Speci	(fy)
100	ding Ph h. After th funeral	ate:	27. Manner of Deatl 1 Natural	5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe	how injury	occurred	
Sion	f or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be	28e. Place of Injury - At he	ome, farm, street, fact	1 Yes 2 No	28f Location	(Street and	Number or Rui	al Route Number,
Division	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	al Cer	4 Homicide	determined	building, etc. (Specif				wn, State)	TVarriber of Flan	ar riode rearrison,
	Hosp 24 hou Funer rtely fil	Medical	(Check 2	Medical Examin	cian: To the best of my know er: On the basis of examination	on and/or investigation,	in my opinion, death occurred	at the time, date	and place, a	and due to the o	ause(s) and manner stated.
	To the within 2	ž	20h Signature and	title of certifier	Practitioner: To the best of		9c License number		20d Date	signed (Month	Day Yearl
	F ≥ F ŏ		• 1	11000.1	L V		20064413		Jan	uary 1	4,2012
V	Dis .		30. Name and addr	ress of person who co	ompleted cause of death (Iter	n 23a) (Type, Print)	,			- 1	
	4.		Tuanita 31. Date filed (Mont		mpleted cause of death (Iter MD 940)	Medical C	enter Drive,	Rocki	ille,	Mary la	rd 20840
	Sta Registr			2012 Zen	32. Registrar's Signa	Kel					

		4	State of Mary		artment of H <i>tificate of D</i>		lental Hygi	ene g. No. 20	12	02605
			Registrar 1. Decedent's Name (First, Middle, Last)		incate of B	- I	2. Date of Death			3. Time of Death
	Physicia: Medic	al	Yosef Hugo Haybok				Month Januar	y Day 2	0 <u>12</u>	3:10 PM
	Examin		4a. Facility Name (if not institution, give street and number) Frederick Memorial Hos	spital	4b. City, Town, or	Location of Death Trederick		4c. County	of Death Frede	rick
ž:	Funeral		5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthp Count	lace (State or Foreign fry)
Н.	Director		578-54-7778	9 Yrs.			Nov. 8,	1922	A	ustria
	show show	tor		c. City, Town or Lo	cation				11	0d. Inside City Limits 1 Yes 2 No
	e Mary r 28a-1 notifie	Director	Maryland Frederick		Mount 10f, Zip Code	Airy	10	g. Citizen of	What Coun	
	with th	Funeral	12694 Monnier Court			21771			USA	
	death items ner mu		11. Marital Status 12. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - Americ	
336	within 72 hours after death with the Maryland glene. glene: er than "natural", or items 23a or 28a-f show ithe Medical Examiner must be notified at ithe Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates.		1 ☐ Yes 2 € No	Specify:		Specify	. Wh	ite
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Mai	2 sho	8	19a. Informant's Name/Relationship (<i>Type, Print</i>) John Haybok, Son		ing Address (Street a					
_				20h Place of Dien	ocition (Name of		Data	20c Location	- City or To	own. State
Baltimore,	8 ± o		4 ☐ Donation 5 ☐ Other (Specify)	Crema	opolitan torium, i	nc. Jan.	15,2012	Alexan	dria,	Virginia
Bal	permit. Par Department Important any injury		21. Signature of Foreral Service licen	FRY 1	2. Name and Addres lolesworth 26401 Ride	-William re Road.	s, P.A., Damascus	Funer MD 2	a1 Ho:	me
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ou c	ath. rr: Aftel he fune	ficate	1 Natural 5 Pending (Month, Day, Ye 2 Accident Investigation	ear) injury	M 1 🗆	(? Yes 2 □ No				
Division of Vital Records,	or Atte	Sertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury-building, etc. (S	- At home, farm, s Specify)	treet, factory, office		28f. Location (St. City or Town		ber or Rura	l Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the tim	e, date and place, a	and due to the cau	ise(s) and mai	nner as sta	ted.
	the Ho hin 24 the Fu	Med	(Check only one) 3 Certifying Nurse Practitioner: To the basis of exam	est of my knowledg	e, death occurred at	the time, date and p	lace, and due to th	e cause(s) and 9d. Date sign	manner as	stated.
	To with		29b. Signature and title of certifier		29c. Licens			4	ed (IVIONIN, -/i2.	Day, Icai)
	_		30. Name and address of person who completed cause of death	h (Item 23a) (Type,	, Print)	erik				
	6		Karny Weishaar 400 v	V. 7ths	t. Fred	enuc	MD Z	170]		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's JAN 1 7 2012	Signature A. A.	barked					

12-00448 David Hanna Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	R	For State	o,	Cen	tificate of	Death				g. No.	201	2 0260
Physician/	1	. Decedent's Name (First, Middle,Las				<u>-</u>	_		Date of Deat Month	Day	Year	3. Time of Death 0404 hrs
Medical Examine		David Mat a. Facility Name (if not institution, given	thew Han	na		h City Tow	n, or Locatio	n of Death	January 16		unty of Death	04041110
	4	Calvert Memorial Hospita					rederick			Calv	-	
Funeral	5	Social Security Number 6. S	ex 7. Age	(In yrs. la	st birthday)	If Under 1		nder 24Hrs	_	th(MM/DD/	YYYY) 9. Birth Foreign	nplace (State or
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'n	_	Jsual Residence of Decedent 0a. State 10b. County		10c. City,	Town or Locati	on						10d. Inside City Limits
P P P	ľ	MD Calvert		,		ngtow	n					1 Yes 2 X No
the Maryland or 28s-f sh tified at one Director	1	0e. Street and Number			Hullel	10f. Zip Co			11	0g. Citizen	of What Coun	try?
3a or 3		1870 Emmanuel Ch	nurch Road				20639				JSA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. To Re Completed by Funeral Director	1	Marital Status Never Married 2 Marrie	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.\$ V ⊐			of Hispanic C Cuban, Mexic		pecify Yes or No Rican, etc.)	- 14.	White, etc.	an Indian, Black,
ter des			of Yes, Give Year	∆_ No	1	Yes 2 X	No speci	ify:		Spe	ecify: Whi	.te
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-003 I withi giene.	<u>.</u>	12 7. Father's Name (First, Middle, Las	1)		Stud	ent	18.Moth	her's Name	e (First, Middle, I		ication	
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Examiner		Immediate Cause (Final disease a or condition resulting in death)	Hanging Due to (or as a conse	equence of	f)·							Dealit
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760, icate be executed physician and the burial - transit	- S	UNPENDED	AMENDED							_		
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b. Box 687 the death certification by the attending ched for use as the brushing of the forms and the forms and the forms are th	2	past 12 months?	1 Live birth 4 Pregnant at	time of	- =	tal death her <i>(Specif</i>		opic pregn	anoy	""		,
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Hot Hot Fun	<u>.</u>	29a. Certifier 1 Certifying Physic (Check only)	clan: To the best of mer:On the basis of exa	y knowled	lge, death occu	rred at the ti	ime, date and	d place, an	d due to the cau	se(s) and r	manner as stat	ed. e cause(s)
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	-	/ / / / / / /	The same				O.C.M.E.			Janua	ary 17, 201	2
. (1)	+	30. Name and address of person wh								1		
dru 5			stant Medical Ex			altimore	Street, Ba	ltimore,	MD 21223			
Star Registra		31. Date filed (Month, Day, Year)	2012 32. Registra	ar's Signat	d. So	telal						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #5, 1/20/12, RM, Kent State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 17, 2012 JANUARY RALPH EDWIN HICKS 10:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN 23885 EAST FORK DRIVE 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 **X** M 2 □ F Months 03/16/1947 PENNSYLVANIA Director 64 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at **Funeral Director** 1 Yes 2 X No MARYLAND KENT CHESTERTOWN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a UNITED STATES 21620 23885 EAST FORK DRIVE items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Completed 3 Widowed 4 Divorced WHITE Year or Dates 1966-67 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) U.S. MARINE CORP RETIRED MARINE CORP 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ FLORENCE OLIVE REHN SAMUEL EDWIN HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23885 EAST FORK DRIVE CHESTERTOWN, MARYLAND 21620 BARBARA HICKS / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 01/19/2012 STEVENSVILLE, MARYLAND . Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deal Immediate Cause (Final Ptoxician/ INDER disease or condition Medical resulting in death) **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes After this certificate 25. Was case referred examiner? 26. Place of Death (Check only one) 2 No 유 1 Inpatient 2 ER/Outpatient 3 IDOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 28c. Injury at 27. Mag er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pending Natural 1 \(\text{Yes} 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 0

+

29a. Certifier

(Check only one

96. Signature and title

31. Date filed (Month, Da

3

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

	_1	For State of Maryland / Department of Health and Welftal Tryglene 2 1 2 State Registrar Certificate of Death Reg. No. 2. Date of Death	UZ6U8
Physicia /Medic	in al -	1. Decedent's Name (First, Middle, Last) ADCT E. HAROLD, SR. Month Day Year 2 2012	1751 M
Examin Funeral Director	5	4a. Facility Name (If not institution, give street and number) 5 O Chech re Lave 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Day, Year) Cour	Search State of Foreign (State of Foreign VA
natural", or items 23a or 28a-f show dical Examiner must be notified at	ctor	MD Prince George's LANTAM 100 Citizen of What Could	0d. Inside City Limits 1 ☐ Yes 2 ☐ No htty?
r items 23a or 2 niner must be no	Funeral	10e. Street and Number 10f. 2lp Code	can Indian,
ene. than "natural", c ne Medical Exan	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private	dustry
and Mental Hygic is marked other t aumatic event, tt	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zing Street and Number or Rural Route Number, City or Town, State, Zing Street and Number or Rural Route Number, City or Town, State, Zing Street and Number or Rural Route Number, City or Town, State, Zing Street and Number or Rural Route Number, City or Town, State, Zing Street and Number or Rural Route Number, City or Town, State, Zing Street and Number or Rural Route Number, City or Town, State, Zing Street Route Number, City or Town, State, Zing Str	o Code)
Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 20a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Ocernation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Tourist Company of State Company of State Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place) 20c. Location - City or Tourist Company or other place)	706 own, State MO 2002
ysician Médical		23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d	-
by the attending phitached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Month	very Day Year
signed by d be detac	by	1 Yes 2 No 3 Pr	1
	Completed		topsy findings available completion of cause of 2 ☐ No
S :-	ation: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 6 Residence 6 Other (Spe	
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	al Certification:		s stated.
within 24 hd To the Fun completely	Medical	29a. Certifier (Check only edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month of States)	= to the cause(s)
R		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBRTID WETTZ 1525 GRENWY TO GRENDE	149829
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Bignature	>

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month JAMES JANUARY MARVIN HALEY 2012 12:55 a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Oueen Anne's Centreville Oueen Anne's Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 🔀 M 2 🗆 F Months July 24 Marvland 1941 219-36-7159 70 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director MD Talbot 1 Tes 2 X No Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31623 Miller Rd. 21625 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 Widowed 4 X Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Battery Plant Assembly Lineworker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I မ Earl Joseph Haley Martha Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Arlene Thompson (daughter) 31623 Miller Rd. Cordova, MD. 21625 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal for injury or Kent Cremation Services 1/25/12 Smyrna, DE. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 21. Signatur eral S n M00510 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or con mion resulting in 1 th) Malignant Medical Due to (r) a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil 0 Due to (or as a cons us ce of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Unknown 9 Unknown been signed by i should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed 2 🗆 No Yes 2 🛭 No 1 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospice examiner Hospital 1 Tyes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: nours after death.

neral Director: After the filled in by the funera. 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours To the Funeral Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of cer D0039887 Jan. 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar David H. Smith,

M,D.

Chestertown, MD, 21620

100 Brown St

32. Registraria Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 53 P M ESTHER R. HARMON - Month Physician/ 9019 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square 0 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months (Month, Day, Year) 7/31/1932 Country) 212-30-0147 **Director** 1 🗆 M 2 💢 F 79 MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is nawked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director Middle River MD Baltimore 1 Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 3829 Clarks Point Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Nidowed 4 □ Divorced Completed tarmon, Esther Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Manufacturing Factory Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Chester Vickers Esther Pearl Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Esther Mae Strebeck/Daugh. 3829 Clarks Point Rd., White Marsh, MD 21220 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Slate Ridge Cem. 1 X Burial 2 Cremation 3 Removal from State 1/28/2012 Delta, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA - Kover 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. ardiogenic disease or condition Medical resulting in death) Due to (or as a lonsequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Examiner burial-transi Cause (Disease or injury that initiated events resulting in death) Last oronary arter Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Month 5 Other (specify) Day Pregnant at time of death signed by the at d be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? death? certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending Natural work?
1 Yes 2 No 2 Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ceratifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature Resodoo Name and address of pe on who completed cause of death (Item 23a) (Type, Print) 9000 Square Drive haltimore MD. 21037 Franks

State

Registrar

FEB 0

32. Registra/s Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 12 0.1 10:55P™ DANIEL KNOTT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES CLINTON CLINTON NURSING If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours Min (Month. Dav. Year) 59 214-58-4736 Director 10 - 28 - 5Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No PRINCE GEORGES VA CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9211 STUART LANE 20735 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married ð Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) CUSTODIAN JANITORIAL 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 JAMES KNOTT MARY DADE KNOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PLACE WALDORF MD JOYCE KNOTT-NIECE 6065 RED SOUIRREL 20603 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-12-2012 STAFFORD VA STAFFORD AMAA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JANAZAH SERVICES LLC LEE RD CHANTILLY VA 20151 14640 FLINT 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ iv. hel disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events tran Due to (or as a consequence of) resulting in death) Last ending physician a use as the burialby Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death 5 Other (specify) detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Completed has page 2 Certificate: To Be

the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate director. after death

			1 🗆 Yes 2 🗆	□ No 3 □ Probably 4 □ Unknow			
			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical		26. Place of Death (Check	only one)				
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ [OOA Other: 4 Nursing Ho	ing Home 5 Residence 6 Other (Specify)				
27. Manyfier of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year) injury M		28d. Describe how injury				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	28f. Location (Street and City or Town, State)	Number or Rural Route Number,				
29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occured a	at the time, date and place, an	d due to the cause(s) and	manner as stated.			

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d, Date signed (Month, Day, Year)

WASHINGTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE

31. Date filed (Month, Day, Year State JAN18 Registrar

(Check

only one)

3 29b. Signature and title of certifier

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Lillian A. Lapp 11, January 4:50p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 500 Chapel Court Unit 106 Walkersville Frederick If Under 1 Year Age (In vrs. last birthday) If Under 24 Hrs **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Director 213-42-7782 1 □ M 2 🏝 F Yrs 99 Usual Residence of Decedent Jan. 30,1912 Pennsylvania 28a-f show 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland Frederick Walkersville 23a or 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 500 Chapel Court Unit 106 21793 United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No þ Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 🛚 Widowed 4 🗌 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Casterline Tillie Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Pusateri/ Daughter 18620 Glen Willow Way, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery1/17/2012 Silver Spring, MD 21. Signature of uneral Serv 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ nemu TUL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the t the attending IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 ☐ Yes 2 ₩ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed' death? ☐ Yes 2☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 TANO Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' death. 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗆 No Investigation n 24 hours after deatle Funeral Director; 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check within 2 29d. Date signed (Month, Day, Year) only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tile of certifier 29c. License number 1181

State Registrar

DHMH 17 Rev 06-2011

30. Name and/address of person who

Ýear)

31. Date filed Month,

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 10:50 A M Barbara Jean Lusby Januarv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clin<u>ton</u> Prince George's Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min 217-36-9373
Usual Residence of Decede **Director** 1 🗆 M 2 🗶 F 06-16-1939 72 Marvland show 10a. State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 No MD Prince George's Upper Marlboro 10e, Street and Number 10f, Zip Code ō 10g. Citizen of What Country? pe must be Funeral 8606 Croom Road 20772 permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ☐ Yes 2 😿 No If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) P.G. County Board Elementary/Secondary (0-12) College (1-4 or 5+) 12 School Bus Driver of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Warren Cochran Ruth Rebecca Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Frank Lusby, Spouse 8606 Croom Rd., Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 01-20-2012 Trinity Episc. Cem. Upper Marlboro, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. William ario M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 00 Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Directo (or as a nonsequence of, cause. Enter Underlying Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): a ending physician For use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each hours after death.

Funeral Director: After this certificate has been signed by the a ending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day signed by the a Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 21 No 3 ☐ Probably 4 ☐ Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 🗌 Yes 2 🗌 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ Other: 2 10 □ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred - Watural 5 Pending 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMONINA

32. Registra s Signature

11.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amenditem 5 per fh g938 4-29-13 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 16, 2012 Thomas Franklin Long Jan. 3:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 29876 Polks Road Princess Anne Under 1 Year | If Under 24 H Somerset 8. Date of Birth (Month, Day, Y Feb. 21, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 215-38-0327 **Funeral** Year) 1933 Maryland Days 1 ØM 2 □ F 78 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. The latter 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Maryland | Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.

14. Race - American Indian,
Black, White, etc. 29876 Polks Road Funeral 21853 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1954 If Yes, Give Year or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer <u>Agriculture</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Thomas Long ို Florence Baylis Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun once. Frances C. Long Wife 29876 Polks Road, Princess Anne, Md. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beechwood Cemetery | 01-20-2012 | Princess Anne, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licensee MO0295 11673 Somerset Ave, Princess Anne, Md. Approximate Interval Between Onset and Death Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Impodiate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a conseque ce f): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as it inneadments of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ed by the detached 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 ☐ Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has I page 2 s autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After Hospital or Attending Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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30. Name and agdress of person who

31. Date filed (Month, Pay, Year)

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28. Place of Death (Check only one) 28. Manner of Death 1	Rec The I	녌							1 🗸				2 No
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30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	f Vi Physi er this ral dir	၉	1 Yes 2 No	I III III patierit 2									icene
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30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			MIL 1	(/m)							_		
Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			30. Name and address of person who con	mpleted cause of death (I	tem 23a)			-					
31 Date filed (Month Day Year) 32 Registrar's Signature	iru ia 1			•	•	00 W. Balti	imore S	Street, Ba	altimore, MD	21223			
Registrar JAN 19 2012 Anna B. Barks	St				nature	barka	R				-	·	

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ # Month 0631 neine anuare 2012 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** SIVEY hestertown Kent 6. Sex '. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Months Days Hours 12/09/1940 PENNSYLVANIA Director 159-32-4824 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 XNo **KENT** KENNEDYVILLE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 29176 RICKS LANDING ROAD 21645 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COSMETIC CHEMISTRY 12 5+ FORMULATING CHEMIST marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev RITA SHIELDS WILLIAM CRANNY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29176 RICKS LANDING ROAD KENNEDYVILLE, MD 21645 JAMES MURPHY / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREAMTION 01/18/2012 STEVENSVILLE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SMOCK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MPHOMA Sequentially list conditions. Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown the 9 Unknown ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an sate has by page 2 s autopsy perforn After this certificate I Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ၉ Inpatient 2 I ER/Outpatient 3 I DOA Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 No Accident
Suicide Investigation
6 Could not be within 24 hours after death

To the Funeral Director,
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature nd title of certific 29d. Date signed (Month, Day, Year) 30 2012 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46085 CHESTEZTOWN 21620 BROWN 100 10 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar 1/18/12, M.S., Kent Co. Amended#26 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Moreland thornton Physician/ Month Marie 11:45 AM 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN KENT 203 BROWN STREET 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Hours 08/05/1924 DELAWARE Director 220-20-4035 87 Usual Residence of Decedent Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 29a-f ehou 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No ABINGDON MD HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2701 MERRICK WAY 21009 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. β 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LOUISE BOULDIN EUGENE THORNTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 MERRICK WAY ABINGDON, MARYLAND 21009 SUSAN BUTLER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 01/13/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND Kick of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and D Immediate Cause (Final Ph_sician/ FAILURE TO THRIVE disease or condition month Medical resulting in death) Due to (or as a consequence of) Examiner ALZHEIMERS 5 years DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year Dav 1 Yes 2 D Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CUNUNARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed OS TECHNITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Brother 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Home 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours after uses...

To the Funeral Director. A 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 1-13-12 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen A Noble MD 122 Speer 122 speer Rd. Chestertown, MD 21620 rns 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02618 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 14, 2012 William Anthony Nogay 4:15 RM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise Senior Living Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 235–24–4699 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days **Director** 1 ₹ M 2 □ F 91 April 16, 1920 Ohio Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland|Montgomery Silver Spring 10f. Zip Code 20904 10e. Street and Number 10g. Citizen of What Country? Funeral 11621 New Hampshire Ave. Apt. 214 U.S.A. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, White Armed Forces?

X Yes 2 No 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give 1939–1959 Year or Dates 1939–1959 Specify: 3 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cost Analyst Private Industry age 1 and 2 should be filed wi snt of Health and Mental Hygie nt: If item 27 is marked other y or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anthony Nogay Veronica Jamrocik 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
Mary Land 20004
Mary Land 20004 19a Informant's Name/Relationship (Type, Print)
Mary Nogay / Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place) 2/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Arlington, Virginia 22. Name and Address of Facility ${ t George\ P.\ Kalas\ Funeral\ Home, P.A.}$ 21. Signatur Funeral Service Livense alas 6160 Oxon Hill Rd., Oxon Hill, MD. 20745 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Immediate Cause (Final Onset and Death ADVANCED DEMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Vear Pregnant at time of death the a g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by should be Hypertension, Depression 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2XXNo မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother Assit. Living сотрете filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 🛚 Natural 5 Pending work? 1 Tes 2 No within 24 hours after death To the Funeral Director: A Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29c. License number ٩ 29d. Date signed (Month, Day, Year) Smansin

Registrar

Date filed (Month, Day N 1 8 2012

Shyamsundar Rajan MD 9801 Georgia Ave. #117 Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D53362

01/16/2012

20902

Pleased Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patrick J. O'Sullivan 2012 9:47a M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1101 Riverwalk Place Apt. Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 212-72-7116 **Director** 1 X M 2 D F 50 1961 Washington, DC Usual Residence of Dece April 9, at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number ō 10f. Zip Code must be r 10g. Citizen of What Country? 23a Funeral 1101 Riverwalk Place Apt.#121 ral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 No Specify: If Yes, Give "natural", Completed Specify 3 Widowed 4 Divorced Year or Dates White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Patrick J. O'Sullivan Frances Elaine Coufal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. O'Sullivan / Mother 20523 Addenbrook Way, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/14/2012 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Stauffer Crematory 1/14/2011 Frederick, Maryland Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 r complications that caused the death. Do not enter the mod only one cause on each line. Part 1. Enter the disease, shock, or heart failure. Lis Approximate nterval Between Immediate Cause (Final Physician/ POVS disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transi resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the de th certificate be Box 68760 ttending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year signed by the Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy death? perforn To the Hospital or Attending Physician: The Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 Elizabeth M Orgel 5.31AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges 2519 Shadyside Ave Suitland . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 X F Hours 577-48-3681 75 12/19/1936 Director Washington DC Usual Residence of Decedent 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Prince Georges Suitland 1 XYes 2 No 10e. Street and Numbe ms 23a or must be r 9 10f. Zip Code 10g. Citizen of What Country? Funeral 2519 Shadyside Ave 20746 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner ŗ Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", 3 Widowed 4X Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk NSIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ပ Department of Health and Ment; Important: If item 27 is marked any injury or conpe Carl F. Haas Laveria Stewart 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Orgel (Son) 10421 Oak Hill Ct. Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01/23/2012 Suitland, Maryland 21. Signature of Lab ral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Date to for as a consequence of or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an has page 2 autopsy certificate 1 🗆 Yes 2 🗆 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify, this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After t 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46478 1-18-2012 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunatts Rd. Clinton. MD 20735 Patel mo 7501 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Me	ental Hyg	iene	00601
			1 - State Registrar Certificate of Death		leg. No. 2012	02621
L	Physicia Medic		Carol Ann Parker	2. Date of Death	th 1 Pay 2 Ola	3. Time of Death 2. 1610 M
	Examin				4c. County of Death Allegany	
	Funeral Director		160-44-8112 Images Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	**
	and show	tor	Usual Residence of Decedent	ec. 31,		nsylvania 10d. Inside City Limits
	e Mary r 28a-f notifie	Director	PA Somerset Springs 10e. Street and Number 10f. Zip Code	54		1 🗌 Yes 2 🔀 No
	with th	Funeral	10e. Street and Number 10f. Zip Code 15562	1	I0g. Citizen of What Cou USA	ntry?
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
-003	ours aft atural", cal Exa	eted l	3 Widowed 4 Divorced If Yes, Give Year or Dates. 1 Yes 2 X No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation		Specify: Wh:	
21215-0036	within 72 h /giene. ner than "n.	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	3	16b. Kind of Business/In	dustry
d 2	be filed wir ental Hygie ked other ic event, tt	Be	17. Father's Name (First, Middle, Last)		Restaurant faiden Surmarne)	
Maryland	nould be filed with and Mental Hygier is marked other tumatic event, the	To	Trans rates	llips		
Ma	and 2 should be fil Health and Mental tem 27 is marked ther traumatic eve		19a. Informant's Name/Relationship (Type, Print) Barry V. Maust/Husband 19b. Mailing Address (Street and Number or Rural F			Code)
Baltimore,	Page 1 an nent of He ant: If iterr ary or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	te 2	20c. Location - City or To	
altin	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatorse of Fyneral Service Licensee 22. Name and Address of Facility New		2 Springs, neral Nome,	
m	permi Depar Impo any ir		P.O. Box 116, Salisb	oury, PA	15558	
اللام	Physician/		23a. Part 1. Errter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line. Immediate Cause (Final	espiratory arres	st,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. He Morris C STLOKE Due to (or as a consequence of):			IDAY
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	and -transit	xami	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
09	ath certificate be executed attending physician and for use as the burial-transit	lical	Sequentially list conditions, if any, leading to immediate course. Enter to darking Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
9289	ertificat ding physe as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
Box	ed ed	siciar	in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 1 Yes 2 No		23d. Date of deliver	ery Day Year
P.O.	law requires that the death as been signed by the atter	by Phy		23e. Did toba	acco use contribute to the	ne cause of death?
	equires	ted b	ted b	1 🗆 Yes	s 2 🗆 No 3 🗀 Prol	pably 4 Unknown
Vital Records,	The law re ate has be page 2 sh	omple	Completed	24a. Was an autopsy perform	prior to co death?	osy findings available mpletion of cause of
E E	rsician: The law s certificate has t		o 25. Was case referred to medical 26. Place of Death (Check or examiner?		. No 1 ☐ Yes	2 No
7 7	Physic r this co	유	P 1 Yes 2 No Plospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home		nce 6 Other (Specify)
lon (tending leath. tor: After the funer	ificat	27. Manner of Death 27. Manner of Death 28a. Date of injury 28b. Time of injury 28c. Injury at work? 1	a. Dooonso nov	r injury occurred	
Division of	cal or At s after of al Direct ed in by			f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledica	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and conversed at the time, date and conversed at the time, date and conversed at the time, date and converse	e time, date and	place, and due to the cau	use(s) and manner stated.
_	To the within To the comp	2	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month, I	
		اہر	S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6	ANUARY	19,2012
		-	William Lamm, MD, 12500 Willowbrook Rd., Cumberland, MD	21502	}	
	Stat Registra	e r				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **d**anth 2012 Wilma Frances Paugh 20:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Co. Memorial Hospital Garrett Oakland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗷 F Days Hours Min. (Month, Day, Year 06 24 1 Yrs **Director** 220-74-5643 84 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 K Yes 2 No MD Garrett Kitzmiller 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 108 W. Center Street 21550 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the 8 own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John A. Kent Della S. Sharpless Department of Health and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalee Evans-daughter E High St, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 1/17/2012 Mt. Zion Cemetery Swanton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signature of Funeral Service Licens 21 N 2nd St, Oakland, MD 21550 23a. Part 1 Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
3 www.k shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes Other: မ Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No

The law requires that the death certificate be Box 68760 P.O. Records, of Vital

Baltimore, Maryland 21215-0036

or Attending Physician: Division within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu To the Hospital or within 24 hours at To the Funeral D

Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation 6 Could not be

determined

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Date filed (Mo State Registrar

Accident Suicide

4 - Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

19812

12-00519 Marilyn D. Ruffin	Please Typ Sta	e or Print in Blate of Maryland	ack Indelible / Department	Ink. Ensure of Health and	e All Copies A d Mental Hygie	\re Legib lene		2 0262
	1- For State Registrar		Certificate			Reg. No		
Physician/ Medical Examiner		ıffin			M Ja	ate of Death onth Day Inuary 18, 20	012	3. Time of Death 1732 hrs
	4a. Facility Name (if not institution Meritus Medical Cente			4b. City, Town, or Hagerstown	Location of Death	1	lc. County of Death Washington	
Funeral Director	5. Social Security Number 546-72-2181	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Yea Months Days	- Hause Min	Date of Birth (MN 4/01/19	9. Bird Foreig Cor	hplace (State or ⁿ California untry)
ru l	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits
Maryland 28a-f show any d at ouce. ector	Maryland Fred	erick	Burkit	tsville				1 X Yes 2 No
the Maryland a or 28a-f sh tified at one Director	10e. Street and Number			10f. Zip Code			itizen of What Cour	
with the	116 East Main S	Street 12. Was Decedent		Vas Decedent of His	718 spanic Origin? (Specify	Yes or No-	ted Stat	
r death with or items 23 Const be no Funeral	1 Never Married 2 Ma	1 Yes 2	X No		n, Mexican, Puerto Ricar	n, etc.)	White, etc.	
rs after ural", miner.	45 Bread at Education (See	orced If Yes, Give Year or Dates: ify only highest grade con	npleted) 16a. Deced	Yes 2 X No	tion (Give kind of work of	done 16b.	Specify:Whit	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or	5+) during	most of working life.	. DO NOT use retired)			
-003 I withir giene. ther th	17. Father's Name (First, Middle,	5+	Econo	mic Analy	S t 18.Mother's Name (Firs		ederal Go	vernment
215. be filed mal Hy riked of ear, th	Marion Doss				Mabel Strei			
D 21 should wind Me 'is ma	19a. Informant's Name/Relationsh				on Dr., Ros			
and 2 fealth a	Margaret White 20a. Method of Disposition		20b. Place of Disp	osition (Name of cer	metery, Dat	te 20d	Location - City or	
TOF	1 Burial 2 X Cremation 4 Donation 5 Other Sp			n Cremato	Januar ry 201		Frederick	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	21. Signature of Funeral Service	Licensee	22 R	Name and Address esthaven	s of Facility Funeral Ser	rvices,	Skkot Co	dy P.A.
Physician	23a. Part I. Enter the disease, or	complications that caused	the death. Do not ente	501 Catoc or the mode of dying,	such as cardiac or resp	Ln Hwy oiratory arrest, s	Frederic hock, or heart	k, MD 21701 Approximate Interval
/Medical	failure. List only one cause Immediate Cause (Fin disease	77 . 3	ia					Between Onset and Death
xammer	or condition resulting in death)	Due to (or as a cons		Exposure				
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons		mpobule.				
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):					
and and	X UNPENDED	dAMENDED23a	-b,pt.II,2	7,28a-f,pe	er me,g925	3-7-12	sn	
'60, ate be ohysicis ne buris	IF FEMALE:	23c. If yes, outco		-			3d. Date of deliver	
Division of Vital Records, P.O. Box 68760, epital or Attending Physician: The law requires that the death certificate be executions after death. seral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - ran Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	4 Pregnant at	time of death 2 5	Fetal death 3 Other (Specify)	Ectopic pregnancy		Month [Day Year
O. Be at the d by the grached Y Phy	Part II. Other significant conditi	ons contributing to deat	h but not resulting in th	e underlying cause o	given in Part I.			the cause of death?
S, P.(juires that a signed lid be det	Hypertensive	Atherosclere	otic cardio	vascular	i i	1 Yes 2 24a. Was an		pably 4 VI Unknown
Division of Vital Records, P.O. Box pital or Attending Physician: The law requires that the death ours after death. In a Director: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use this proper in the funeral director, page 2 should be detached for use the filted in by the funeral director, page 2 should be detached for use the filted in by the funeral director.						autopsy performed	prior to	completion of cause of
ital Fician: certification rector,	25. Was case referred to medical examiner?		ent 2 🗸 ER/Outpati		of Death (Check only of Other Nursing Ho		dence 6 Othe	
of Vige Physical Characteristics of The Chara	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inj. (Month, Day,)	ury 28b. Time		ry at Work? 28d.	. Describe how i	njury occurred	
ion trending leath. Ator: A the fundant ation	1 Natural 5 Pend 2 K Accident Inves	ing stigation fd 1-18	-12 fd 05:	47 pm		-		heated home
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune ledical Certification:	3 Suicide 6 Coul	d not be	njury - At home, farm, s und:Reside			or Town, State)	116 E. Ma ville,Md.	iral Route Number, City in St.
8452	29a. Certifier 1 Certifying Pt	nysician: To the best of m	y knowledge, death oc	curred at the time, d	ate and place, and due	to the cause(s)	and manner as stat	ed.
To the Hos within 24 h To the Fun completely	one) 2 Medical Example 29b. Signature and title of certifie	and manner stated	mination and/or investi	29c. Licens			d. Date signed (Mo	
	111/		Mis) O.C.			nuary 19, 201	
6	30. Name and address of person			1	Ohraci B. III	MD 04000		
State	Russell Alexander MD 31. Date filed (Month) Way Year)	A	cal Examiner 90 ar's Signature	1	Street, Baltimore	e, MD 21223		
State Registra		17 '11 1'11 1'11 1'17.	can A. A	parkel				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ T2 Jennie Carter Robey 2012 January 9:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4506 Gridley Road Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 215-39-6741 72 **Director** 1 M 2 🔀 F Apr. 12 1939 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Silver Spring 1 Yes 2 X No Montgomery 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20906 Funeral with 4506 Gridley Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Retail Clerk Department Store 11 errut. Page 1 and 2 should be filed wit be artment of Health and Mental Hygiel mportant: If item 27 is marked other in my injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarabelle Ricketts William Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Lee Robey, Sr./Husband 4506 Gridley Road, Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗹 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 1/17/2012 Silver Spring, MD 21. Signature of Fune a Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Der Imr any 20882 P. O. Box 5038, Laytonsville, Maryland dre Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ship ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final Chronic Obstructive Pulmonary Disease Physician/ disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a g Unknown Division of Vital Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy death? perform performed? Yes 2 ⋈ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1× No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 🖒 Natural 5 Pending Accident
Suicide after death Director: / d in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Dir

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI D 35965 January 13, 2012 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, #300, Olney, MD 20832 David B. Harding, M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JAN Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month 6:00 A M Pollyanna Stottlemeyer 15 01 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Dennett Road Manor Nursing Home Oakland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** Country) Hours Min 10 ay, 1924 Director 1 M 2 F 11 203-22-7046 87 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director MD Mt. Lake Park 1 X Yes 2 No Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 21550 USA 304 E Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black White etc Yes 2 X No 1 Never Married 2 Married ō þ Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify. "natural", 3 ₹ Widowed 4 □ Divorced Completed White Year or Dates ntal Hygiene. ced other than "natura c event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) manufacturing inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ Anna Agnes Puffenbarger Herbert Woodell King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mt. Lake Park, MD <u>Jeannie Landon-daughter</u> St. other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/18/2012 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery Signature of Fund al Service Licen 22. Name and Address of Facility David A. Burdock Funeral Home PA N 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to forms a nomeouence off cause. Enter Underlying Exami Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death been signed by the a should be detached Unknown Hospital or Attending Physician: The law requires that the P.O. reignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 10 bacco After this certificate 1 Yes 2 No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation a er death the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar DHMH 17 Rev 06-2011

29b. Signatur

31. Date filed (Month, Day, Yea

JAN 17

and title of certifie

Daniel Buckingham,

address of person who completed cause of death (tem 23a) (Type, Print)

M.D.,

32. Registrar's Signature

29c. License number

D64302

255 North Fourth St, Suite 100, Oakland, MD 21550

29d. Date signed (Month, Day, Year)

1/16/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month -14y--20 9ar2 Physician/ Simmons :07 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Charles Waldorf Waldorf Center 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Maryland Min. 1 0 - 15 - 1924 1 🗆 M 2 🖺 F Months Hours 87 220-32-5065 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a, State traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No or 28a-f Indian Head Maryland Charles 10a, Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 23a Funeral USA 20640 105 Thompson Ln permit. Page 1 and 2 should be filled within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Francisconce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify:Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Home</u>maker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Proctor Lena Μ. Oueen James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandywine Rd, Brandywine MD 20613 Daisy Greenfield-Niece 5701 20b. Place of Disposition (Name of cemetery, crematory or other place a 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Indian Head MD St.Marys Star of 4 Donation 5 Other (Specify) 1-23-12 22. Name and Address of Facility renof Funeral Service Lic 21. Signatu Adams Funeral Home PA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner entine Frequentially list nonctrional, if any, leading to immediate cause. Enter Underlying Examiner sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months? Month Year Pregnant at time of death n signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ension performed. certificate has ocu nu 1 Yes 1 Yes completed filled in by the funeral director, to medical 26. Place of Death (Check only one) 25. Was case ref Be examiner? Other: _2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ after death. Director; After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
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To the Funeral D Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D7119 15/2012 Huse of death (Item 23a) (Type, Print) thon BNCI SWITB, Glen BWNie, MD, 21061

Registrar DHMH 17 Rev 7/2009

State

Name and address of person who completed

			For	State o	f Maryland				Mental Hy	giene	2012	02621
			State Registrar			Cen	tificate of L	Death	2. Date of De	Reg. No.		3. Time of Death
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	Medic	al .	Leon 4a. Facility Name (if not institution,	give street and num	iber)			r Location of Dea			County of Deat	
	Examin	er	Southern Mar				Clin	ton		Pr	ince (George
5	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Bir Co	thplace (State or Foreign untry)
	Director		220-38-3198 Usual Residence of Decedent	1 🔀 M 2 🗆 F	69	Yrs.			4-5-1	942	Wash	nington DC
	and show	'n	10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
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٥	er dez or ite miner	by F	1 Never Married 2 Marr	Armed Fo	rces? 2 \(\text{No} \) 1 \(\text{C} \)	164	Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)		Black, Whit Specify:	e, etc.
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פר	be fled within 72 hours after death with the Maryland and all Hygiene. Red other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be c	17. Father's Name (First, Middle, L	ast)				18. Mother's N	lame (First, Middle	, Maiden		
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Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Tuneral Service I	icensee	2	22	. Name and Addre	ess of Facility				20.600
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x 687	ending r use (an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1 ☐ Live	tcome of pregna	ancy al death 3	Ectopic pregna	ncy			23d. Date of d	elivery Day Year
Box	death the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pre 9 ☐ Uni	gnant at time of a known	death 5	Other (specify)				Wichiti	Day roa
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<u>S</u>	ital or A								and due to the	20100(2)	and mannor as	etated
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach	Medical	(O) 1 Sendingl	g Physician: To the Examiner: On the b g Nurse Practition	acic of ovamination	on and/or inve	stigation in my oni	nion death occur	red at the time, dat	e and piac	e, and due to th	e Cause(s) and manner stated.
	Fo the within Fo the Somple	Σ	only one) 3 L Certifyin 29b. Signature and title of certifie		er. 10 the best of	my knowledge		nse number	A		ate signed (Mor	
			1 Committee	an, M	D.		D.7	212		10	1/13	1/12
,	221		30. Name and address of persor	who completed car	use of death (Iter	m 23a) (Type,	Print)	01.0	Ann .	md	nn	25
	puy		31. Date filed (Month, Day, Year)	1505	Registrar's Signa	ature T	42 NC	1.6.111	11011	HC	1 001	
	Sta Regist		JAN 18	2012	and a	1 1	a still					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland Jen 3 per dr., g924,02	Pepartment of Health and Certificate of Death	Reg. N	2012 02628
	Physicia		1. Decedent's Name (First, Middle, Last) Jack Schoen		2. Date of Death Month January 1	3. Time of Death 10:15 a.M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		c. County of Death
سجديد	/		11060 Weymouth Court Apt.# 207	Waldorf		Charles
	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 TF 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Year)	g. Birthplace (State or Foreign Country) 929 Washington, D.C.
			Usual Residence of Decedent		Бер. 20, 1	
	yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ★ Yes 2 □ No
	or 28a	Dire	Maryland Charles Waldon 10e, Street and Number	10f. Zip Code	10q. C	Ditizen of What Country?
	with the same same same same same same same sam	Funeral Director	11060 Weymouth Court Apt.#207	20603	USA	Α
	death items ner mi		11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	al", or	d by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🏌 No Specify:		Specify: White
2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Total of Dates.	Decedent's Usual Occupation (Give kind of work done during most of wo	orkina 16b.	Kind of Business Industry
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Baltimore, Maryland	permit. P Departm Importar any injur		21. Sign are of Juneral Service Licensee	22 Name and Address of Facility	Lunt Fin	recal Home
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Division of Vital Records, P.O.	tal or / s after al Dire		4 I Hornicide determined building, etc. (Specify)		City or Town, Sta	ate)
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	29a. Certifier 1 V Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occurre	ed at the time, date and pla	ace, and due to the cause(s) and manner stated.
	o the vithin 2 or the omple	ž	only one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	ledge, death occurred at the time, date and 29c. License number		Date signed (Month, Day, Year)
	->-0		> mit a feather ms	021031	/	1/13/12
	Da-4		30 Name and address of person who completed cause of death (Item 23a) Pare and Liether was 12010 old	(Type, Print) Une Center Suite	302 Walda	£ mo 20401
	Sta		31. Date filed (Month, Day, Year) JAN 19 2012 32 Registrar's Signature	1.41		
	Registr	ar	VIII - V LVIL Kerren B.	Barba		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 02629 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ontre amar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Anne 01 entreville Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1- M 2 - F Min Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "--- any Injury or other than the many or other 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Yes 2 ☐ No Kent Rock Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21249 Loller Lane 21661 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 KNo If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kevin Mitchell Scott Nicole Anita Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 142 Rock Hall, Nicole Scott/Mother MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Aaron Chapel 1/21/2012 Rock Hall, MD 4 Donation 5 Other (Specify) 22 me and Address of Facility 21. Signature of Funeral Service Licens Bennie Smith Funeral Chestertown, MD 21620 Home 855 High ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CHORZA Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year , the a P.O. ed by tl detach signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 N certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) #SPICE H U ြု 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident 3:41 РМ .11.12 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined - outreville OSPI Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nuce Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nuce Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one Signature 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

Hill Rd

Sinto 400 Chestertown Mis 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02630 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HENRY M. Physician/ SABETTI, JR. 2012 **JANUARY** а м 3:00 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min. 1 X M 2 □ F Hours oct. 18 1923 New York 062-14-7443 Director 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Braddock Heights Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21714 Funeral 6835 Maryland Ave. U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ "natural", or 1 Never Married 2 Married filed within 72 hours after all Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. WWII event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vacuum Salesman Vacuum Cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Rose Kolb Henry M. Sabetti, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12822 Shrewsbury Church Rd. Kennedyville, MD.21645 Henry M. Sabetti, III (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Kent Cremation Services 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/26/12 Smyrna, DE. 21. Signature of Paneral Service Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 . Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death SEPSIS Physician/ disease or condition Medical resulting in death) Examiner Bactremic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decubitus Vicer Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneermonio 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pi 24 hours after death. Funeral Director: After the Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 2 🗌 Accident 3 🔲 Suicide 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) D. 50653 1. 25 - 2012 BIM aymu c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUXANA church ton Deale

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Rola

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02631 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY CHARLES 2012 DAVIDSON STARTT 5:15 \mathbf{a}^{M} 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehab Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min (Month Day) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign

Physician/ Medical Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Schwarz John Edward Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country)
 PA If Under 1 Year If Under 24 Hrs. Date of Birth 7. Age (In vrs. last birthday, **Funeral** Jan 24, ^{Year} 1926 1 XM 2 □ F **Director** 86 210-18**-**0069 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State must be notified at Director Cumberland 1 Yes 2 X No MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral 23a USA 21502 12206 Bowling Street items . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after If Yes Give white WW II "natural", Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N School System Teacher/ Coach 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Bruner ည Karl Schwarz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) MD 21502 Cumberland 10233 Christie Road NE Linda Gerwig daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/30/2012 MD Flintstone 22. Name and Address of Eacility Scarpelli Funeral Home, PA ignature f Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Betwee Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events Due to (or as a consequence of) resulting in death) Last yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No examiner? Hospital: Other: Inpatient 4 Nursing Home 5 Residence 6 Other (Specify, ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 28b. Time of 27. Manner of Beath Natural 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Bu

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) January Physician/ 12, 2012 1:00 A M Phuc Thi Tran Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Walkersville Glade Valley Center If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Nov. 15, Months Hours 1 □ M 2 🖾 F , Year) 1927 Vietnam 84 Director 070-70-8152 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 Yes 2 No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21702 9414 Boulder Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc Armed Forces þ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 Asian 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker (unk Be (unk.) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9414 Boulder Road, Frederick, MD 21702 Margaret Tran / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. Tata, 1 ☐ Burial 2XX Cremation_ 3 ☐ Removal from State Frederick, Maryland Resthaven Crematory 2102 4 Donation 5 Other (Specify) 21. Signature of Service Licensee Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Enter the disease, or Approximate Interval Between shock, or heart failure. List Onset and Death Immediate Cause (Final disease or cond) on resulting in dea h) Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ending physician are use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred

Division of Vital Records,

After this certificate the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 27. Manner of Death 1. Natural 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Yes Certificate: (Month, Day, Year) iniury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

completed cause of death (Item 23a) (Type, Prin

Registrar's Signature

29b. Signature a

Name and address of p

title of c

rtifie

Registrar

29c. License number

29d. Date signed (Month,

2012

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1ARDAN 3:00 A M Tanyary 16,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAGERSTOWN YNNEHAVEN DR. # 6 WASHINGTON 9. Birthplace (State or Foreign Funeral (Month, Day, Director and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director HAGERSTOWN 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 filed within 72 hours after death with YNNEHAVEN DR.#6 Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) HARMACIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental rtant: If item 27 is marked i jury or other traumatic ev 2 TSERETELI MURTAZABEG MIJAVVAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/74/2 SON BAKHRAN 501 LYNNEHAVE Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 Cremation 3 Removal from State EM. 01 116/2012 FREDERICK MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio inse 22. Name and Address of Facility ADEN MUSLIM FLNERAL SEC MO#1070 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph sician 1000 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and tran that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 2 No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 N death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred Natural Accident work? injury 5 Pending 24 hours after death. Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Raymond N. Taylor 20/2 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO REGIDNAL MEDICAL 544156414 If Under If Under 24 Hrs. 9. Birthplace (State or Foreign Year 8. Date of Birth . Age (In vrs. last birthday) **Funeral** Min. (Month, Day, Year) 577-20-2361 Hours 94 1 **☑** M 2 □ F **Director** May 8,1917 Maryland Usual Residence of Deced or 28a-f show notified at $^{\rm a.~State}$ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Somerset Princess Anne 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be n 29772 Polks Road Funeral 21853 United States within 72 hours after death "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. White 1 Never Married 2 Married by ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry h and Mental Hygiene.

27 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene W. Taylor 2 Mary E. Pusey Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. David A. Taylor Son 4560 Cooper Road, Eden, Maryland 21822 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Asbury Methodist Cem. Jan. 21,2012 1 Burial 2 Cremation 3 Removal from State Allen, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home M00295 1673 Somerset Ave. Princess Anne. 11. Enter the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between diate Cause (Final Onset and Death Physician/ Constitut heart dis ase or condition Medical resulting in death) Due to (or as a consequence of): Examiner Althorosularoite cardio vascular Sequentially list conditions, Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and use as the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 certificate 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛣 No Certificate: To 1 Inpatient 2 X ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1X Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D68222 01/16/12

Registrar

State

Kaz

31. Date filed (Month, Day,

Year)

JAN 19

E.

100

Carroll St. Salisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.M.C

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 18 2012 Year Physician/ 1:45 A M Robert Walter Webb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Care & Rehabilitation E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days 1 XM 2 - F Months Hours Min (Month, Day, Year) 6/19/1946 Yrs **Director** 218-46-0775 Usual Residence of Decedent or 28a-f show notified at be filed within 72 hours after death with the Maryland ential Hygiene. Ked other than "natural", or items 53a or 28a-f sho rice event, the Medical Examiner must be notified at ice event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil Rising Sun 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21911 111 Greenmount Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Veterans Admin Manager Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic eveni once. 17. Father's Name (First, Middle, Last) 2 Hubert Webb Ruth Geraldine Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mallory Way North East, MD 21901 Kimberly Copen - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/21/2012 Rising Sun, MD 21. Signatur Juneral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, PA S. Queen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician d be detached for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After injury 1 Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

3+1VA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

32. Registrar's Signature

NARAYANA RA,

KTWN MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY 2012 15:02 PM4 VIRGINIA LUCILLE WARD WALLS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 940 Hours Min APRIL 9, 1 □ M 2 😾 F VÍRGÍNIA 212-40-5636 71 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No MARYLAND CECIL NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 24 KINGS WAY DRIVE 21901 UNITED STATES Examiner must items ; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceus. Armed Forces? 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc nd Mental Hygiene. marked other than "natural", or i 1 Never Married 2 Married þ Yes Yes, Give Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the HOUSEKEEPER MANUFACTURING other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be filed of Health and Mental Hitem 27 is marked ot GEORGE RIFFEY JOSEPHINE THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24 KINGS WAY DRIVE, NORTH EAST, MARYLAND 21901 DENNIS WALLS / HUSBAND permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition JANUARY 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State NORTH terEAST TOWN TEED CO. 20 NORTH EAST, MARYLAND METHODIST_CEMETERY 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. Siz 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to (or as I that the death certificate be executed and that initiated events Due to (or as a consequence of); resulting in death) Last ng physician a as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 A No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires the 124 hours after death.
 Funeral Director: After this certificate has been sign Unknown 1 Yes 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2 prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Inpatient 2 ER/Outpatient 3 DOA မ completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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DHMH 17 Rev 7/2009

Registrar

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

main St.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Amendment, #5 Per funeral director 01/25/12 cm For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia Medic		Evelyn E	lizabeth	Welch	า				Jan.	12, Day 201	1 2 ^{ear}	1:20P M
	Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, o	r Location	of Death		4c. County		
-			Dennett Road	Manor			Oakla	nd			Ga	arret	tt
	Funeral		5. Social Security Number	6. Sex 7. Age (i	In yrs. last birtho		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th (Vear)	9. Birthp	place (State or Foreign
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Ĕ	Page ant: ury o		4 Donation 5 Other (Sp				l Garde		1/1	7/2012	Oakl	and,	Maryland
Baltimore, Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee /		22.	Name and Addre	ss of Facili	y Nev	wman F	uneral	Hom	es P.A.
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ď	: The cate										2 No	1 🗌 Yes	2 🗆 No
ta	ician sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			26. P	lace of Dea	th (Ch)	k only one)			
<u> </u>	hysi this c	은	1 Yes 2 No	1 Inpatien	t 2 ER/Out		3 LI DOA	4 N			idence 6 - Oth		2
ō	ing F	ate	27. Man of Death Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		me of ury	28c. Injur work	</th <th>. </th> <th>28d. Describe</th> <th>how injury occur</th> <th>red</th> <th></th>	.	28d. Describe	how injury occur	red	
<u>6</u>	tend leath or; A	iţi	2 Accident Investig 3 Suicide 6 Could r	not be				Yes 2	No				
Division of Vital Records,	or At fter c irect n by	Certificate:	4 Homicide determine		r - At home, farr (S <i>p</i> ec <i>ify)</i>	n, stre	et, factory, office			28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
Ö	vital ours a ral D								- 4				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To the best of m kaminer: On the basis of exa									
	the hin 2	M		Nurse Practioner: To the be	est of my knowle	dge, de			e and plac	e, and due to t			
	5 ≥ 6 8		29b. Signature and title of certifier	1			29c. Licens		33	>	29d. Date signe	a (Month,	Day, Year)
)							113	0.5	>>		15	12
		2	30. Name and address of person w								=		
		2	Dr. Thomas Jo				urth St	·., ()akl	and, N	MD 2155	0	
	Stat	te	31. Date filed (Month, Day, Year)	32. Kegistrar's	s Signatur	had	we						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 08^{Day} 20 1°2 Elwood Wilson 1724P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month Day, Year 29 1 ★ M 2 □ F 82 Months Hours Min **Director** Yrs. Washington DC Feb. 578-36**-**9770 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Yes 2 No Charles MD Waldorf 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? with items 23a Funeral 2529 Lisa Road 20601 · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 A Yes 2 No
If Yes, Give Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: White "natural", Specify. 3 Divorced 4 Divorced Year or Dates. Army Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12th Refinisher Furniture other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Elwood Wilson Frances May Catlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important; If item 27 is any injury or other tra 2529 Lisa Road Waldorf, Maryland 20601 Mary Wilson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Jan.12,2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licenses Washington Road, Waldorf, Maryland 2060 01d 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, or respiratory arrest. shock, or heart failure. List only one cause on ea Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Line to (or a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Was an has autopsy performe death? Yes 21 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 Inpatient ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of . Date of injury (Молth, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print Berwa 31. Date filed (Month, Day, Year) 3. Registrar's Signature JAN 19 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar 1/18/12, M.S., Kent Co. Amended#26 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01/15 2012 Year ELIZABETH LEE WASSERMAN 1:30P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 536 HIGH ST CHESTERTOWN KENT Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours **Director** 214-42-3149 1 M 2 K F 71 August 27,1940 Virginia iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Director Centreville Maryland Queen Anne's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21617 USA 206 Kidwell Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian or. Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed Specify: 3 □XVidowed 4 □ Divorced White Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Federal Government Court Reporter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Lee Murray Elizabeth Shumate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> item 27 Page 1 and 2 Maryland 21620 <u>Jonathan Wasserman/ Son</u> 536 High Street Chestertown, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date Chesapeake Cremation Cntr 1/17 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kick S Fellows, Helfenbein, Newnam FH Chestertown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only Interval Between Immediate Cause (Final Onset and Death Physician ١Ł disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events burial-tra consequence of) resulting in death) Last attending physiciar Physician/Medical that the death certificate be Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the and to be detached for Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 2 No Physician: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 ■ Residence 6 X Other (Specify) Son's Home Division of 28c. Injury at work? Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I To the only one) 29b. Signature and title of certifie SICICI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Pearl Thomas Wilt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Western Maryland Reg. Allegany Med. Ctr. Cumberland Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Mir (Month, Day, Year) **Director** 213-64-9443 1 - M 2 X F Berryville, VA 85 Jan. 29,1926 Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No WV Mineral New Creek 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o Funeral HC 72, Box 112 26743 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Lawrence W. Wines Pearl T. Wynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Strother/Granddaughter 72, Box 112 New Creek, WV 26743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jan. 4 Donation 5 Other (Specify) Potomac Memorial Gardens 2012 Keyser, WV 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Acute Renal disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** RVEYR malnourishmen Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Mayor depression Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (ex as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death the : Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> sign 1 be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has, autopsy performed certificate 2 🗌 No Yes 2 🔽 1 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at work?
1 Yes Certificate: 28b. Time of After 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fu Accident 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

Almi Bhandan

2012

D0071867

12500 Willow Brook Rd, Cumberland, MD 2/502

M.D

WMHS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 James Month Leonard Ziler JR 1233 Medical Examiner 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death WMHS-Regional Medical Center Hlegany umberlana Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, March 3 1 🕱 M 2 🗆 F Hours Min ^{Year)} 1956 Maryland 212-74-6609 Director 55 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 522 Maryland 21502 Ave. United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1974
I Tyes 2 \sum No 1975
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lumber Saw Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Ziler SR Shirley Mayhew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milburn Ziler/ brother 21406 New Georges Creek RD, Westernport, MD 21562 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Bloomington Cemetery 01/20/2012 Bloomington Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician lyocardial disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death the g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Baltimore, Maryland 21215-0036

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, H0056080 ou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O. 17204 McMullon Huy S.W. Cum Allison Evans-wood 31. Date filed (Month, Day, Year)

JAN 2 0 2012

State Registrar

Ch

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Arbogast Ilene M 8:1101 February 2013 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Eastpoint 7601 Carson Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) (Month, Day, Year) 1 □ M 2 😿 F 275-36-0488 72 May 30, 1939 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No Baltimore Eastpoint 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 7601 Carson Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 X No Black. White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Poling Poling Heater Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie M. Arbogast, daughter 7601 Carson Avenue Eastpoint, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 02/02/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Ph_sician/ Medical Examiner

and

certificate

To the Hospital or Attending Physician:

Physician/

Medical

10a, State

MD

Examiner

Funeral

Director

or 28a-f show notified at

ō

er than "natural", or items 23a or the Medical Examiner must be r

and Mental Hygiene.

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i

Director

Funeral

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Completed

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical isigned by the Within 24 hours after deavn.

To the Funeral Director, After this to the funeral Director After this to the funeral director.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	shock, or heart failure. List only	one cause on each line.			Interval Between						
	Immediate Cause (Final disease or condition	Leulemia			Onset and Death						
	resulting in death)	Due to (or as a consequence of):									
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unsease or murry	b. Due to (or as a consequence of):	b. Due to (or as a consequence of):								
edical Ex	that initiated events resulting in death) Last	Due to (or as a consequence of):									
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	ctopic pregnancy other (specify)		23d. Date of delivery Month Day Year						
ted by Pl	Part II. Other significant conditions of	contributing to death but not resulting in the unde	erlying cause given in Part I.		o use contribute to the cause of death? No 3 Probably 4 Unknown						
Comple				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No						
Be	25. Was case referred to medical		26. Place of Death (Check	only one)							
To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient	3 □ DOA Other: 4 □ Nursing Ho	me 5 Residence	6 Other (Specify)						
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? M 1 \(\subseteq \text{ Yes} 2 \subseteq \text{ No} \)	28d. Describe how inj	ury occurred						
Medical Certificate:	3 Suicide 6 Could not I 4 Homicide determined		factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)						
Medica	(Check 2 Medical Exam	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investiga rse Practitioner: To the best of my knowledge, de	ition, in my opinion, death occurred at	the time, date and pla	ce, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier /		29c. License number	29d. E	Date signed (Month, Day, Year)						

DOOST465 2/2/12
Baltimore MD 2/209

Registrar DHMH 17 Rev 06-2011

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MShyapanem-D

N. S Rajapaksemo

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2-1-2012 Day Physician/ Ronald Adams 7:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 3405 Louth Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Hours Director 214-38-4916 1 XM 2 - F October 6, 1940 Maryland 71 28a-f show 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a, State Director Examiner must be notified Dundalk 1 Yes 2 XNo Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 items 23a Funeral 21222 USA 3405 Lough Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. o, 1 Never Married 2 X Married Yes 2 XNo þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important, If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) General Foreman Welding Company 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Johnson Thomas Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Lough Road, Dundalk, Maryland Jo Ellen Adams wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Februäry 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Middle River, Maryland Holly Hill Memorial Cons 4, 2012 21. Signature of Fundral S 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 101176 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode, I dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on poline.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death n signed by the af 4 Pregnant g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24 No Records, 1 \square Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy perform within 24 hours after death.

To the Funeral Director, After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurve Fractifier in T. The best of my fractions are stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philosolphia Ro. #314, Bolimere, MD State Registrar

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			State Registrar		Cer	tificate of	Death		Reg. N	10.20	12	02645
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	and 2 sl Health a tem 27 is		Josey R. Anthon	(wife)	511 W	indwood	Road_	Baltimore,	Ma	rylan	d 2	1212
ore	of Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		ce of Dispo	sition (Name of natory or other pla	ice)	Date		Location - 0	•	
Ë	Page ment tant:		4 Donation 5 Other (Spec	fy) Fore:	st Ri	dge Ceme	tery	1-30-12	Up	perco	, Ma	ryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	see	22 M	Name and Addre	ess of Facility Wiedef	eld Funera Baltimor	1 H	ome.	Inc.	01.01.0
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	the H hin 24 the Fi	Med	only one) 3 🗹 Certifying Nu	rse Practitioner: To the best of my		death occurred at	the time, date		the cau	use(s) and ma	anner as	stated.
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)			30. Name and address of person who Susan Anthony	completed cause of death (Item 2 CRNP 6701 N.			.+ C+-	. /.10E m		3.5	-	1 21207
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State Registrar DHMH 17 Rev 06-2011

			For State Registrar	State of	Marylan		artment of F		d Mental Hy		012	02	646
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ور	Examili	iei	Future Care Pine Vi	-	•		Clinton	EGGGGGG G G			nce Geo	rge's	
	Funeral Director		5. Social Security Number 220–01–3195	6. Sex 7. 1 □ M 2 □ F	Age (In yrs. la 91		If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of B	irth 1920 ar)	9. Birthp Coun	olace (State o	r Foreign
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Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if them 27 is marked outher than "natural", or items 23a or 28a-f show if it item 27 is marked outher than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.		19a. Informant's Name/Relationshi Lena Brahame-Kirkpa		er		ng Address (Street a					Code)	
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E	:. Page tment tant: It jury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	Rive		rematory		23-2012	Riverda	le, Mar	yland	
g	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Li				. Name and Addres dar Hill Fl		A Ave., SU	itland, M	D 20746		
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VISION	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of	Injury - At ho , etc. (Specify		eet, factory, office			(Street and Num wn, State)	ber or Rural	Route Numb	er,
5	ospital hours a ineral C	Medical (29a. Certifier 1 Certifying	Physician: To the bes	t of my knowl	edge, death o	occured at the time,	date and place	e, and due to the c	ause(s) and mar	nner as state	d.	
	the Hothin 24 the Fu	Mec		aminer: On the basis Nurse Practioner: To				e time, date and		he cause(s) and r	manner as sta	ated.	nner stated.
	1 3 1 8			1)				185	45	29d. Date sign) - Invioritri, t	16, 2	212
	4		30 Name and address of person w	ho completed cause	of death (Item	23a) (Type, P	DUD (1)	18-1	SUZZ	WA	CROAL	F. L	use .
	Stat		31. FEB (1°2' 2012')	32. Reg	rar's Signat	Willed .	71			, 0 - 11	2	06	02
	Registra	ar	. 55 0 . 55 . 7										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0302 M Physician/ arlton 2012 Danuary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** aryland Medical Baltimore Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) 15-68-0239 Director 1 M 2 □ F 6 MARVIAND permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director BALTIMORE 1 Yes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21218 U.S.A NORTHWICK 12. Was Decedent Ever in U.S Armed Forces? 12 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 No 1977 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced BLACK 1979 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) School System Elementary/Secondary (0-12) College (1-4 or 5+) SECURITI UNIKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRITT LEROY AUGUSTA LYNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNSON Rd. Krystal Daughter 1535 MARVIANS BALTIMORE Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 02/10/2012 Owings Mills, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) C. JONES FIH, PA 22. Name and Address of Facility THE DERRICK HGTS. AUE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (CEREBRAL VASCULAR ACCIDE Pnysician/ Uncal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical P.O. Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page, death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: ဂ္ဂ 1 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 304 ristan Meador, MD 301 Warren 31. Date filed (Month, Day, Year) State FEB 0 2 2012 Registrar

DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Baker Susan 31 J. 4:45 Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7536 Whaler Court Glen Burnie Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** 212-68-3868 **Director** 1 🗆 M 2 💢 F 42 April 20, 1969 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Glen Burnie 1 Yes 2 X No MD Anne Arundel 10e Street and Number ō 10f. Zip Code 10g, Citizen of What Country? must be Funeral items 23a 7536 Whaler Court 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö 1 Never Married 2 X Married by 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🗓 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Golden James Joyce Blacksten other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau David C. Baker, husband 7536 Whaler Court Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 02/01/12 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, - E. Mac Mill 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate rval Between Onset and Death Immediate Cause (Final Physician/ a disease or condition mont Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to lor as a consequence of trar Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has tompletely filled in by the funeral director, page 2 s autopsy death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, 1 ☐ Yes 2 ☑ No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

01

305 Hospital Drive, Suite 2A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Gayatri D. Nimmagadda, M.D.

31. Date filed (Month, Day, Year)

February 1, 2012

21061

Glen Burnie, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 3 I 20°12 Doris Kathleen Baldwin 11:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline House Frederick Frederick Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X□ F Country) Hawaii Months Days Hours (Month Day Year) 11/05/1924 **Director** 217**-**24-1297 87 Yrs Usual Residence of Decedent 28a-f shov 10a, State 10b. County with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Yes 2 No MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 105 Sandstone Dr. Apt. 229 21793-9008 **USA** permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2X Married 2X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francis Leo Attridge Lena Marie Pantkratz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice E. Baldwin / Husband 105 Sandstone Dr. Apt. 229, Walkersville, MD 21793-9008 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/2/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury tran and that initiated events Hospital or Attending Physician; The law requires that the death certificate be exect Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 I 9 Unknow the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence eral Director: After this filled in by the funeral di 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XINatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the or certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

FEB U 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sarah J. Bruce January 2012 4:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 □ M 2 🔀 F 87 5/30/1924 **Director** Maryland 216–16–6716 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD n/a 1

Yes 2 □ No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 820 S. Caton Avenue, Apt. 9L 21229 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) CLerk a Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosario Faggio Concetta Marsiglia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Bruce, Jr. / Son 1619 Terrace Drive, Westminster, Maryland 21157 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Donation 5 Other (Specify) Bayview Crematory 2/1/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EPTIC WICER DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year signed by the at d be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE Completed 1 Yes 2 No 3 Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes the Hospital or Attending Physician; 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No HOSPICE မြ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending iniury i ofter death.

Director: After a n by the fur 2 Accident
3 Suicide Investigation within 24 hours after de
To the Funeral Directo
completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044

DHMH 17 Rev 7/2009

State Registrar 6336

DANIEUE DOBERMAN, MO

32. Registrar's Sign

12-00781 Thomas Boss Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar	Certifi	cate of	Death		F	Reg. No.	
Physicia bal Examir	ın/	1. Decedent's Name (First, Middle,Last) Thomas		Bos	s		2. Date of Dea Month January 2	Day Year	3. Time of Death 1056 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center		4	o. City, Town, or L Baltimore	ocation of Deat	n	4c. County of Deal	h
Funeral Director			(In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24Hr		irth(MM/DD/YYYY) 9. Bi	gn n. T
Director	-	039-24-7495 1⊠M 2□F €	68 	Yrs.			April	19,1943 c	ountry) RI
w any	Ī	10a. State 10b. County 1	Oc. City, Tow	n or Location		hester			10d. Inside City Limits 1 Yes 2 X No
viaryland 28a-f show i at once.	Director	CT Hartford 10e. Street and Number			10f. Zip Code			10g. Citizen of What Co.	
auth with the Maryland items 23a or 28a-f sho sst be notified at once.		60 Ferguson Road			06040			United St	ates
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fahor or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (S Mexican, Puert	pecify Yes or N Rican, etc.)	o- 14. Race - Ame White, etc.	rican Indian, Black,
after de	J. F.	3 Widowed 4 Divorced If Yes, Giva Year or Dates:	No		Yes 2 X No			Specify:	White
2 hours		15. Decedent's Education (Specify only highest grade complete lementary/Secondary (0-12) College (1-4 or 5+			s Usual Occupation st of working life. I			16b. Kind of Business	/Industry
5-0036 led within 72 hours i Hygiene. other than "naturs the Medical Exami	Completed	12 Years		Busi	ness Own			Transport	ation
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Bec	17. Father's Name (First, Middle, Last) Chester I. Boss			118		e (First, Middle, abeth R	Maiden Surname) olan	
MD 21215-003 d 2 should be filed withi lth and Mental Hygiene. n 27 is marked other th numatic event, the Med		19a. Informant's Name/Relationship (Type, Print) Ellen M. Paul (Sister)	1					mber, City or Town, Stat iamsburg, V	
nore, MD 2 ages 1 and 2 shou not of Health and Nort: Witem 27 is no	ł	20a. Method of Disposition			ion (Name of ceme		Date	20c. Location - City o	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		Burial 2 K Cremation 3 Removal from State Donation 5 Other Specify:		op Se	rvice Co	-	31/2012		Maryland
Balti permit. Departm Importa		21. Signature of Funeral Service Licensee		22 Na Du	ame and Address of da-Ruck	Funeral	Home o	f Dundalk,	Inc. 1222
hysician		23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	e death. Do	not enter th	e mode of dying, s	uch as cardiac	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner	İ	Immediate Cause (Final disease or condition resulting in death) a Hypertensive Ath Due to (or as a conseq		tic Cardio	vascular Dise	ease			Death
	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseq	uence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq							L
ecuted and transit		d.							
760, icate be extracted physician the burial -	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome	of pregnant	.				23d. Date of delive	nv
ox 687(eath certifica attending ph for use as the		23b. Was decedent pregnant in the past 12 months?		2 Fet		Ectopic pregn	ancy	Month	Day Year
Box 68 e death certification the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown			er (Specify)				
ires that the signed by the detache	2	Part II. Other significant conditions contributing to death t	out not result	ting in the ur	nderlying cause giv	ven in Part I.		tobacco use contribute to es 2 No 3 Pro	
Records, The law require	Completed						24a. Was		utopsy findings available completion of cause of
tal Recc	E S						1 Yes	ormed? death? 2 ✓ No 1 1	'es 2 No
/ital ysician;	å	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗸 ER	/Outpatient	Ic	of Death (Check Other Nursi	only one)	Residence 6 Oth	er:
ading Phy.	ion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Yea	28l	b. Time of In		at Work?	28d. Describe	how injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	Suicide Could not be	ry - At home	, farm, stree	t, factory, office bu	ilding, etc.	28f. Location or Town,		tural Route Number, City
DIVIS To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, d	death occurr	ed at the time, date	e and place, an	d due to the cau	use(s) and manner as sta	ated
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated. 29b. Signature and title of certifier	nation and/o	or investigati	29c. License		at the time, date	e and place, and due to the and 29d. Date signed (M	
_		Callie 111	/(4	O.C.N	1.E.		January 28, 20	12
HIV		30. Name and address of person who completed cause of dea Zabiullah Ali, M.D. Assistant Medical Exa			altimore Stree	t, Baltimore	, MD 21223		
St	ate	31. Date filed (Month, Day (Or) 32. Registrat's		Kel					OUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For .
State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death Month Physician/ imathy Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore City 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Social Security Number **Funeral** Days Months Hours 1 🔀 M 2 🗆 41 Maryland **Director** 220-86-6446 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore 1 Yes 2 No MD Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21237 Funeral United States 9609 Baron Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 2 1 ☐ Never Married 2 😾 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No White Yes Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Supervisor 7 Years 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Trixie L. Adkins Timothy L. Bury, Sr. 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Andrea L. Bury (Wife) 9609 Baron Place Rosedale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 🗵 Burial 2 🗆 Cremation 3 🗀 Removal from State Stanislaus Cemetery 2/3/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland Ave. Wise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. Li List only one cause on each Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 4 Pregnant 9 Unknown Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 Probably 4 Unknown 1 Yes 2 No Should Be Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate has be irector, page 2 s autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital 2 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 \sum Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 🗌 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific

100

State Registrar

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ BUTLER 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON MEDICAL CENTER MARYLAND ARUNDEL GLEN BURNIE ANNE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) cial Security Number Age (In yrs. last birthday) Funeral Months 74 Director Germany November 6, 090-34-8562 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No Severn MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7819 Bastille Road 21144 <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗌 No If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dental Care Dental Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Irmgard Elise Michel William Friedrich Harms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7819 Bastille Road Severn, Maryland 21144 William A. Butler, Jr./Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 3, 1 Burial 2 X Cremation 3 D Removal from State 2012 Odenton, Maryland 4 Donation 5 Other (Specify) Arundel Crematory W. 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 of Fundal Service Licensee M01386 Part 1. Leter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death STAGE IDIOPATHIC PULMONARY Pnysician/ END disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Day Pregnant at time of death 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No Be

To the Hospital or Attending Physician: The law requires that the death certificate be exect Division of Vital Records, P.O. Box 68760 s certificate has the firector, page 2 s this within 24 hours after death.

To the Funeral Director: After of the funeral place in by the funeral completed filled in by the funeral place.

25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28c. Injury at work? 1
Yes 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending 2 No М Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

REDD Hospital Drive, Glen Burnie, Maryland 21061 M.D. 301 31. Date filed (Month, Day Year)

29c. License number

29d. Date signed (Month. Day, Year)

2012

State Registrar 12-00877 Shayvon Booker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of Deat		Reg.	No. 201	2 0265
Physic		Decedent's Name (First, Middle,Last)			-	2. Date of Death		3. Time of Death
edical Exam	iner	Diray von	Booker	1 0:	To a local to a financia	Month Da January 29,		2335 hrs
		4a. Facility Name (if not institution, give s University Hospital	treet and number)	4b. City, Baltir	Town, or Location of Deat nore	n	4c. County of Death	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		ler 1 Year If Under 24Hr	s. 8. Date of Birth(N		hplace (State or
Director		218-37-8176 ₁ X _N	ı 2□F 19	Yrs. Month			Carala	n untry) MD
*un		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	_	MD NA	Ba	ltimore				1 Yes 2 No
faryla 28a-f	Director	10e. Street and Number		10f. Zip		10g.	Citizen of What Cour	ntry?
the N	ā	455 Yale Avenu	ıe	21	229		USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Witena 73 in marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No		ent of Hispanic Origin? (S ify Cuban, Mexican, Puert		White, etc. A	can Indian, Black, frican
after o		3 Widowed 4 Divorced If	Yes, Give Year	1 Yes 2	No specify:		specify: Ame	rican
hours	귷	15. Decedent's Education (Specify only			Occupation (Give kind of rking life. DO NOT use re		6b. Kind of Business/I	ndustry
21215-0036 Ide be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4 or 5+) NA	Prepare	r	[Ledo Piz	za Co.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	၂၀	17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, Maid	den Surname)	
121 i be fil ental F arked	B	Donnell	Booker	<u> </u>	Devera		Camphor	
D 2. should and M.	ဥ	19a. Informant's Name/Relationship (Typ			S (Street and Number or			
and 2 sho ealth and cen 27 is		Devera J. Camp 20a. Method of Disposition	20b F	Place of Disposition (Na	Le Avenue	Date 2	Oc. Location - City or	Lanu Town, State
Baltimore, MD 2 Permit. Pages 1 and 2 should pepartment of Health and N Important: If item 27 is n miny or other traumatic		1 X Burial 2 Cremation 3	Removal from State	Canalo y or other place Poutus Me	m. Pk. 02	-04-12 -	Oc. Location - City or Randallst	own MD
Baltin permit. P Departme Importar		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	e	22. Name and	Address of Facility W	vlie Fur	neral Hon	ne P.A.
E F P E		Sumerla Ju	moston		Liberty R	oad Rand	dallstown	n, MD 21133
Physician /Medical		23a. Part I. Enter the disease, or complic failure. List only one cause on each	ations that caused the death. line.	Do not enter the mode	of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
<i>E</i> xamine			unshot wounds (2) of			_		Death
		b	e to (or as a consequence of).				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e to (or as a consequence of):				
0 =	Examine	(Disease or injury that initiated C	e to (or as a consequence of	f):				
Da Basis	A	d						
760, cate be executed physician and the burial - transit	Medical	UNPENDED X	AMENDED 20b, c	per fh g924	4 2-2-12 vt			
760 ficate g phys	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy Fetal death	3 Ectopic pregn	ancy	23d. Date of delivery Month)ay Year
Box 687(ne death certifica the attending pl ned for use as the	Physician/	past 12 months?	4 Pregnant at time of de			ancy	MOTOT E	, ay
BO: e deat the at	hys	1 Yes 2 No 9 Unknown	9 Unknown					
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in the the funeral director, page 2 should be deatched for use as the buinklar transit	by P	Part II. Other significant conditions o	ontributing to death but not re	esulting in the underlying	g cause given in Part I.	_	cco use contribute to	_
ds, aquires sen sig	ted				<u> </u>	24a. Was an	24b. Were au	topsy findings available
tal Records cian: The law requi certificate has been ector, page 2 should	Completed			-		autopsy performe	d? death?	ompletion of cause of
ital Recitions: The section, page	ß	25. Was case referred to medical			26.Place of Death (Check	1 Yes 2	No 1 ✔ Ye	s 2 No
Vital hysician this cert			spital: 1 ✓ Inpatient 2		Other :		sidence 6 Other	:
ing Phy After th	⊢	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jan 29, 2012	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	-
ion tendir eath. tor: A	iş.	1 Natural 5 Pending 2 Accident Investigation	Jan 29, 2012 ***/	2302 hrs	1 Yes 2 ✔ No	Subject shot		
Division of Division of Division of To the Hospital or Attending Phyritin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho		y, office building, etc.	or Town, State	e)	ral Route Number, City
ospita hours neeral	_	4 Momicide	(Specify) Local Stree		V. E		on Avenue, Baltimo	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: 0	: To the best of my knowledon the basis of examination and					
To wit	Me	29b. Signature and title of certifier	nd manner stated.	29	c. License number	2	9d. Date signed (Mor	nth, Day, Year)
		6/11/	14	1	O.C.M.E.	J	January 30, 2012	2
H		30. Name and address of person who cou						
٦			ant Medical Examiner		re Street, Baltimore	, MD 21223		
Regis	tate	31. Date filed (Month, Day Year) 2 20	32. Fegistrár's Signatu	1 sail	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2 Date of Death 3. Time of Death Physician/ January 28, 2012 8:10P **JAMES** ROBERT **BROWN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lorien Mays Chapel Baltimore Lutherville Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 1 X M 2 🗆 F 05/102/14926 85 Yrs Marviland 215-18-3105 Director Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be I Funeral 21093 12110 Tullamore Court # 104 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Judae Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed the and Mental H 27 is marked of traumatic ever မ Robert Charles Brown Agnes Forestell permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Mullan Brown Wife 12110 Tullamore Court Lutherville Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 02/02/2012 |Baltimore, Maryland ☐ Donation 5 ☐ Other Specify) ture of Funeral S 22. Name and Address of Facilities Inc 6500 York Road_Baltimore. Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death phlu ailwa Ph sician/ disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 2 N 1 Tes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work 1 Tes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗙 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier COLN 5

State Registrar CHARLES ST

TOWSOR

BUITE 4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FH g951 7/17/13 TRT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Do 12 Day 9 -uski 15 PM **Physician** ean tella Jan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Havre de Grace Under 1 Year | If Under 24 Hr Harford Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1□M 2€F Months Days 89 Pennsylvania 180-18-7849 6/26/1922 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show 1 ☐Yes 2 ☐ No Directo Maryland Harford <u>Aberdeen</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 418 Holiday Drive 21001 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 200 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Modicel Exponee. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker in home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laurence Uszko Pauline Jazawska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21001 418 Holiday Drive, Aberdeen, Rhea Bruski (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial

Cremation 3 ☐ Removal from State Ferris & Company 1/31/2012 | West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 21. Signature of Funeral Servic Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** のれくそろか disease or condition resulting in death) /Medical Due to (or as a continuence of): Dwee KS Examiner POXI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed Effusions 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pericardal 2 🗆 No 2 No 1 ☐ Yes 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1+0071825 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) utrel hnon 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elizabeth M. Cook 0.1 2012 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 06/11/1917 Maryland 1 □ M 2 🔀 Director 94 212-70-8026 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Baldwin Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 er than "natural", or items 23a on the Medical Examiner must be Funeral 13109 Sanfield Road U.S.A. 21013 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaking Own Home 12 permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Born Richard Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 13109 Sanfield Road - Baldwin, Maryland</u> Amy Roberts (granddaughter)
20a. Method of Disposition 21013 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 01/30/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - KIngsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final iancha Physician Myocardia disease or condition Medical resulting in death) Due to or as a consequence of) Examiner TON OU Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami certificate be executed and burial-trar Due to (or as a consequence of): attending physician Medical Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death 5 Other (specify) signed by the aid be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an cate has autopsy performed? Yes 2 100 Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury 5 Pending 1 Natural Accident work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 29a, Certifie

 Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 6701 18, Clorks ST DANON WILLES anson mo 31. Date filed (Month, Day, Year) 62. Registrar's Signature State EEB () Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ М Creigh 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4.5.17 Jessu Year If Under 9. Birthplace (State or Foreign Country)unk If Under 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) 1 M 2 - F Hours Min. 250-40-4865 84 Director Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Washington Hagerstown 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21746 18601 Roxbury Rd. 12. Was Decedent Ever in U.S.UNK
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) $\, unk \,$ 17. Father's Name (First, Middle, Last) unk မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18601 Roxbury Rd; Hagerstown, MD 21746 Captain Steve Rowland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) in State itur of Funera Sovice Ronal o 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final Phylician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for it completed filled in by the funeral director, page 2. in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O.1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 5. Was cas eferred to medical Be Division of Vital 26. Place of Death (Check only one) examiner? 2 🗌 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar he and address of person who completed cause of death (Item 23a) (Type, Print)

12-00905 **Shirley Carmine**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ber		3 Widowed	4 Divor	ced If Yes, Give Ye			1 🔲	Yes 2	No	specify:			Spe	ecify:	Whi	te
5-0036 led within 72 hours after tygiene. nather than "natural", the Medical Examines	<u></u>	15. Decedent's Educa	tion (Specif	or Dates: fy only highest gra	ade completed)	16a.	Decedent	s Usual C	ccupatio	n (Give ki	nd of wor	k done	16b. Kind	of Busin	ness/Indi	ustry
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5-003(led within Hygiene. nuther tha	ᅙᅡ	17. Father's Name (Firs	st, Middle, L				- 5		18	3.Mother's	Name (F	irst, Middle	Maiden Su	rname)		
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21215-0036 Juld be filed within 7 Mental Hygiene. marked uther than market than event, the Medica	0	19a. Informant's Name/				191	b. Mailing	Address	(Street	and Numb	er or Run	al Route Nu	ımber, City o	or Town,	State, Z	ip Code)
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Pag Pag nent ant:		4 Donation 5	Other Spe	ecify:	D	<u>ulan</u>	ey Va	alley	/ Mer	n. Gb	n 2-	4-201	2 'I'in	noni	.m.,	Maryland
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the finneral director, page 2 should be detach		examiner?	No	Hospital: 1	Inpatient 2	ER/C	Outpatient	3 D	OA	Other _	Nursing	Home 5	Residenc	e 6	Other:	
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Division of Vital Records, P.O. Box 68760, Ta the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Ta the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ca	(Check only one) 2 V Me	edical Exar	niner: On the bas	is of examination	n and/or	investigat	ion, in my	opinion,	death oc	curred at	the time, da	te and place	e, and du	e to the	cause(s)
To the within To the comple	Medical	29b Signature and titl		and manne	r stated.					e number						h, Day, Year)
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		30. Name and address		who completed c	ause of death (I stant Medic	tem 23a)	mina-	000 144	Dalki-	noro C+-	ract Da	altimoro	MD 2122	3		
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Regis	(E)					60										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Cunningham, Sr. Month Day Physician/ Thomas Herman 2012 Year Jan. 29 3:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** $M_{ay}^{(Month, Day, Year)}$ 13, 1926 1 □XM 2 □ F Months Maryland Director 85 205-16-5023 Usual Residence of Decedent 28a-f show with the Maryland the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Port Deposit Cecil MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a United States 21904 79 Vineyard Drive items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Year or Dates. WWII "natural", 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 11 Years College (1-4 or 5+) Insurance Industry Insurance Adjuster Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Rose Mary Cerreta George Elmer Cunningham 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Vineyard Drive Port Deposit, Maryland 21904 if Health a Mrs. Barbara G. Cunningham 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from ak Lawn Cemetery 2/2/2012 Baltimore, Maryland 4 Donation, 5 Dother (Specify) 21. Signature Ameral S Duda-Ruck Funeral Home of Dundalk, 10 Dundalk, Maryland 7922 Wise ATTE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Turneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burneral completed filled in by the funeral director, page 2 should be detached for use as the burneral completed filled in the page 1 should be detached for use as the burneral completed filled in the page 2 should be detached for use as the burneral completed filled in the page 2 should be detached for use as the burneral completed filled in the page 2 should be detached for use as the burneral completed filled in the page 3 should be detached for the page 3 should be 3 should be 3 should be 3 should be 4 s Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide

3-11 State

HERMAN, HWY. 533 LUGUSTINE

determined

Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN

Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0062190

29d. Date signed (Month, Day, Year) 30

Suite A, CHESAPEAKE CITY, MD 21915.

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death OMINICIS Month Physician/ Year (1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 2052 Gate Dr. 1 Year If Under 24 Hrs. 6. Sex If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min **Director** 217_38_4056 Usual Residence of Deced 1 M 2 F Yrs Feb 22, 1939 Maryland 72 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location must be notified at Director Annapolis MD Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or 23a Funeral 21401 2052 Gate Dr. death v items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 by 2 X No 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: black. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) 0 home healthcare provider healthcare Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important. If item 27 is marked oth any injury or other transport 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ruth Ella Thomas Isaac Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2052 Gate Dr; Annapolis, MD 21401 Charles Dominick - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) neral Serv 22. Name and Address of Facility State Anatomy Board Rona Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between WEST AND PRATT Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): ding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

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1 Yes 2 No Pregnant at time of death Other (specify) ed by the a detached i 9 Unknown signed by t d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar DEFENSE HWY

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 31 2012 Physician/ 11:15AM M Constance Ann Duffy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 440 West 23rd Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe . Age (In yrs. last birthday **Funeral** (Month 1725/1955 Days Countyland Hours Min Months 1 ☐ M 2 🛣 F 213-66-8411 57 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Funeral items 23a **USA** 21211 440 West 23rd Street death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S 11. Marital Status the Medical Examiner Armed Force Black, White, etc. Yes ō 1 Never Married 2 Married 2 XNo \$ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🛣 No Specify: If Yes, Give White "natural", 3 Widowed 4 Noivorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 72 should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Print Print Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Concetta Detorie **Edward Duffy** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 3312 Upton Road, Baltimore, MD 21234 Sandra Ann Monios / Sister or other 20a. Method of Disposition
1 □ Burial 2 🖾 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 2/2/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of, il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day for Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes ficate has been sig rr, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to mediexaminer? Other: 2 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of 28a. Date of injury 28c. Injury at Certificate: (Month, Day, Year) 5 Pending work 1 Yes 2 No M Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Ye FEB 0 2 2012 completed cause of death (Item 23a) (Type, Print)

		1	For State Registrar		State o	of Mary			artmen <i>tificate</i>			and M	lental Hy	giene Reg. No	71	112	026	563
		0	Decedent's Name (First, Middle	, Last)									2. Date of De	ath			3. Time of I	Death
Physi					Esth	er Lo	ouise 1)eFi	lipp	is			Month Janua:	ry 3	Ď, 2	2012	3:45	РМ
Exan	dica		la. Facility Name (if not institution,	give stre							Location o	of Death		$\overline{}$		of Death		
			6538 Beechwood	d Dr	ive				Col	umbi	a				Howa	ard		
Funer		15	Social Security Number	6. Sex	м 2 🗓 F		yrs. last birti		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept 8		0.5	9. Birthp	lace (State or sylvan:	Foreign
Direct		-	165-20-3039 Jsual Residence of Decedent			86		Yrs.					Sept 8	, 19	25	Penns	sylvan:	La
ind show at		. h	10a. State 10b. County			10	c. City, Towr	or Loc	ation							10	Od. Inside Cit	y Limits
//ary/a 8a-f tified] ec	MD Howa	rd			Colum	bia									1 🔀 Yes	2 🗆 No
the N		<u>ב</u>	10e. Street and Number						10f. Zip	Code				10g. Ci	tizen of	What Count	try?	
s 23s		Funeral Director	6538 Beechwoo	d Dr	ive				21	046				U.	S.A	•		
death ritem ner n		2	11. Marital Status		. Was Dece Armed Fo	edent Ever rces? 2 \(\text{No} \)	in U.S.	13. V	Vas Deced Yes, spec	ent of His	panic Ori	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)			ce - America ck, White, e		
after after xami	1 4	ام	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	ried	1 ☐ Yes If Yes, Giv Year or Da	/e		1	☐ Yes	No 🏋 s	Specify:				Specify	White	2	
nours natura ical E		Completed	15. Deceder		ation		16a.	Deced	ent's Usua	Occupa	tion			_		Susiness Ind		
Z I 3-UU30 in 72 hours after e. han "natural", o Medical Exam		ᇍ	(Specify only higher Elementary/Seconday (0-12)	st grade	College (1		_	(Give k	aind of wor DNOT use	k done du retired)	urin g m os	t of workii	ng				,	
Vithi Vgiene Per the			12				В	ook	keep	er				Re	tai.	l Stor	<u>ce</u>	
ylallo uld be filed I Mental Hy narked oth	19	o Re	17. Father's Name (First, Middle, L										(First, Middle, ne Pru		Surnam	re)		
yld be uld be i Men narke	'	- 1	Rudolph Hosne				- 1				_							
Mal 2 sho th and 27 is r		1	19a. Informant's Name/Relations			h+or	1 1						Route Numbe Columb					139
and and Healt tem Sther		-	Jean E. Minza 20a. Method of Disposition	K /	daug		20b. Place of				<u>u Dr.</u>		Date			- City or To		
DESIGNMOFE, IMERYICATION ZIZID-UUSO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		emoval from		cemete	ry, crem	natory or o	her place			1,2012			-		
DAILLIMORE, Dermit. Page 1 and Department of Hea mportant: If item any injury or othe	انو	ŀ	21. Signature of Funeral Service L		1/		W. AL	_								ii, ra	Lyland	\neg
any per	Si I	4	1.6/49	S	1	MO	00773		Donal 313 T	dson albo	Fune tt A	eral ve.	Home, Laurel	P.A. Ma	rvla	and 20	0707-4	389
			23a. Part 1. Enter the disease, or	complic	ations that	caused the	e death. Do n										Approximate Interval Betv	
Pnysicia	m/	-	shock, or heartfailling. List of Immediate Cause (Final disease or condition	,		Carin	oma of	E Lu	ing	Large	e Cel	1				1 2	Onset and D month	eath
Medic Examin	_		resulting in death)	C a.			nsequence o											-
Examin		<u>.</u>	Sequentially list conditions,	b.												_		
o P is			if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	4	Due to	(or as a co	onsequence o	of):										
and and		LXa	that initiated events resulting in death) Last	c.	Due to	(or as a co	onsequence o	of):										
cate be executed physician and sthe burial-transit		<u>a</u>																
ficate g phy as the	3	led Med		- 0.										-				
endin use			F FEMALE: 23b. Was decedent pregnant	230	o. If yes, ou		oregnancy D Fetal death	3 [Ectopic p	regnancy	,				23d. Da	ate of delive	ry	
death death re att			in the past 12 months? 1 Yes 2 No			nant at tin	ne of death		Other (sp						Me	onth	Day Y	ear
at the	į		g ∐ Unknown Part II. Other significant condition	ns conti	ributing to c	leath but n	not resulting i	n the u	nderlying (ause dive	en in Part		22a Did t	obacco	use con	tribute to th	e cause of de	ath?
es tha	3	<u> </u>	Hypertens														ably 4 🗆 L	
requir seen		ere				- D.: 1		· - D					24a. Was				sy findings a	
e law e law e has ge 2 s		Completed	Chronic O	DSTI	uctiv	e Pul	LIIIOIIAL	у D.	LSEAS	E			auto	psy ormed?		prior to cor death?	mpletion of ca	use of
in: Th	3		25. Was case referred to medical							26 Pla	ce of Dea	th (Check	1 Yes	2 L X N	0	1 Yes	2X No	
VILC Vsicia S cert direct	15	lo Be	examiner? 1 Yes 2X No	Но	spital:	Inpatient	2 🗆 ER/Ou	tpatien	t 3 🗆 D0	Otho	r·		me 5 PResi	dence f	3 Oth	ner (Specify)		
or ig Ph ter thi neral			27. Manner of Death 1. XNatural 5 Pendir		28a. Date		28b.	Time of njury		Bc. Injury work?	at		28d. Describe					
endir eath. or: Af		<u> </u>	1 X Natural 5 Pendir 2 Accident Investir 3 Suicide 6 Could	gation	,,,,,,	, ==,,		37	М		Yes 2 □	l No						
VISI or Att fter d irrect		Certificate:	4 Homicide determ			e of Injury - ing, etc. (S	- At home, fa Spec <i>ify)</i>	rm, stre	eet, factory	, office			28f. Location (City or Tox			per or Rural	Route Numbe	∋r,
pital of purs a ceral p			29a. Certifier 1 X Certifying	Physics	an: To the	nest of mu	knowledge	death o	occured of	thetimo	date and	place on	d due to the ac	مانومادا د	nd man	ner as state	rl .	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: Affect his certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Medical		xamine	r: On the ba	sis of exam	nination and/c	r invest	igation, in	ny opinio	n, death o	ccurred at	the time, date	and place	e, and du	ue to the cau	ise(s) and mar	iner stated.
To the vithin To the complex	2		29b. Signature and title of certifier		V	1/-	0/4	yu, (License	number	San piece	-, aa ace to ti			ed (Month, E	Day, Year)	
			> seffer	11	C - 1	Kay	40-	- 1	7	D3	70	(11		7	_ (1/2	2012	_
Q		ŀ	30. Name and address of person							_								
4			Jeffrey Kaplan							Suit	e A,	E11:	icott C	ity,	MD	210	42	
Regi:	State		31. Date filed (Month, Day, Year)	12	32. F	Registrar's	Signature	all's										
negi	આવા					-												

		_	For State	State of Ma	ryland / [Лental Ну	giene	110	02661
			Registrar			Certific	cate of D	eath	T	Reg. No.	16	02004
	Physicia	n/	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	Medic	al .		ixon		1.0	Oit Tour on	ocation of Death	Januar		2012 ty of Death	8:10 A ^M
	Examin	er	4a. Facility Name (if not institution, give s 8018 Aladdin Drive			40.		_ocation of Death		How	,	
To the Control	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birt		Laurel Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign
	Director		215-44-4780	M 2 XX F	67	Yrs. Mo	nths Days	Hours Min.	(Month, Day Feb. 7	y, Yea <i>r</i>) • 1944	Mary	yland
	MC .	h	Usual Residence of Decedent		10 O': T						1	0d. Inside City Limits
	yland -f sh ied at	cto	10a. State 10b. County		10c. City, Towr	_	11					1 Yes 2 TYNo
	r 28a notifi	Director	MD Howard 10e. Street and Number		Laur		Of, Zip Code			10g, Citizen of	What Coun	
	/ith th	ral	8018 Aladdin Dr	ivo				0723		5	USA	
	ems	Funeral		12. Was Decedent Ev	er in U.S.	13. Was I	Decedent of His	panic Origin? (Sp	ecify Yes or No-		ice - Americ	
ထ္	ter de or it mine	by F	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀 N	10		, specify Cuban Yes 2 🔀 No	, Mexican, Puerto	Rican, etc.)		ack, White, e	
99	ural" ural"		3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.						Specif	. 441	nite
2-("nat" edica	Completed	15. Decedent's Ed (Specify only highest grad		16a	(Give kind o		tion uring most of worl	king	16b. Kind of Howa	Business Ind rd Cot	
12	ithin 7 ene. than he M	5 S	Elementary/Seconday (0-12) 12th	College (1-4 or 5+	-)		OT use retired) Ountant			ı	ic Scl	
0 0	Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)	4		1100		18. Mother's Nan	ne (First, Middle,	Maiden Surnar	ne)	
<u>la</u>	l be fi fental rked tic ev	욘	Charles Edward	Lugar				Ruth R	ebecca	Swomley		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ	e, Print)	195	o. Mailing Ad	ddress (Street ar	nd Number or Ru	al Route Numbe	r, City or Town,	State, Zip C	Code)
Σ	ealth n 27 ner tra		Thomas Arthur Di	xon/Husbar			Aladdin	Drive,	Laurel		0723	
ore	e 1 au i of H if ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place o cemete		n (Name of ry or other place	a)	Date	20c. Location	n - City or To	own, State
Ë	Ement tant: jury		4 Donation 5 Other (Specify		West	-	del Cre		/2012		on, M	
Baltimore,	permit Depar Impor any in	- N	21. Signature of Funeral Service License	mark	, M0110		me and Address					me, P.A.
			23a. Part 1. Inter the disease, or comp	icetions that caused	the death Dou			tt Avenu			2070	Approximate
	ana wasii		shock or heart failure. List only on	e cause on each line.					,			Interval Between Onset and Death
,~~, 	Medical	- 7	disease or condition resulting in death)	a. Due to (or as a			st Canc	er			-	9 yrs
	Examiner				, , , , , , , , , , , , , , , , , , , ,	,						
	1	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):						
V	outed nd ransit	cam	Cause (Disease or iinjury that initiated events	c								
0	e exection and an arrial-t	ical Examiner	resulting in death) Last	Due to (or as a	consequence	of):						
9	eath certificate be executed attending physician and for use as the burial-transit	dic		d								
Box 68760	ertific ding p	M.	IF FEMALE:	3c. If yes, outcome o	of pregnancy					23d [Date of deliv	env
č	atten atten for us	ciar	23b. Was decedent pregnant ' in the past 12 months? 1 Yes 2 ANo	1 Live Birth 2 4 Pregnant at			topic pregnancy her (specify)	y	_		/lonth	Day Year
B	hat the death ed by the atte detached for	Physician/Med	9 Unknown	g 🗌 Unknown								
P.0.	that t ned b deta	by P	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the under	rlying cause give	en in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?
ds,	quires en sig uld b	pa	1						1 🗆	Yes 2 X No	3 □ Pro	bably 4 🗆 Unknown
Sor	aw rec as bee 2 sho	blet							24a. Was	psy	prior to co	psy findings available impletion of cause of
Rec	sician: The law requires that certificate has been signed rector, page 2 should be de	Completed								ormed? 2 X No	death?	2 XNo
tal	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:			26, Pla	ace of Death (Che	ck only one)			
ξ	Physical this call dire	은	1 Yes 2 No	1 Inpatie	ent 2 ER/O	outpatient 3 Time of	28c. Injury	4 ☐ Nursing F	lome 5 X Resi	dence 6 0 0		<i>'</i>)
0 _	ding I h. After funer	ate	1 X Natural 5 ☐ Pending	(Month, Day		injury	work'		28u. Describe	now injury occi	inea	
sio	4tten r deat ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, fa						nber or Rura	I Route Number,
Division of Vital Records,	al or safter		4 - Hornicide determined	building, etc	. (Specify)				City or To	wn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	29a. Certifier 1 Certifying Phys	ner: On the basis of ex	camination and/	er investigat	ion, in my opinio	 n. death occurred 	at the time, date	and place, and	due to the ca	luse(s) and manner stated.
	the H hin 24 the Fi	Me	only one) 13 Certifying Nurs	e Practioner: To the	pest of my know	wledge, death	h occurred at the	time, date and pl	ace, and due to the	ne cause(s) and	manner as s	tated.
_	7 with		29b. Signature and title of certifier	1016.	An.		29c, License			29d. Date sign		
U	5		I www 8	V - Inc.	V			8509		Janua	ry 31	, 2012
	2		30. Name and address of person who c					tor Dr	Cuita C	020 00	Jimhi	a MD 21044
	Sta	te_	Nicholas W. Ko 31. Date filed (Month, Day, Year)	22 Pegistra	r's Signature	1071		CET DI'	sulle G	UZU, CC	Tunib1	a, MD 21044
	Registr		FEB U 2 2012	anen	AA	Charles						

		1	State	partment of Health and N e <i>rtificate of Death</i>	lental Hygien Reg. N	/11// 11/663
			Registrar 1. Decedent's Name (First, Middle, Last)	ortificate of Boats	2. Date of Death	3. Time of Death
	Physicia		Melanie Dowd		January (30, 2012 8:45 PM
	Medic Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			3934 2nd Street	North Beach Jif Under 1 Year If Under 24 Hrs.	O. D. Land Dist	9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \square \text{ M } 2 \boxtimes \text{ F} \end{bmatrix}$ 7. Age (In yrs. last birthda, Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day Year) 03/31/195	57 Maryland
	t ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d, Inside City Limits
	ırylanı a-f sh ied a	Funeral Director		Beach		1 🕱 Yes 2 □ No
:	or 28a notif	흠	MD Calvert North	10f. Zip Code	10g. (Citizen of What Country?
	with the 23a country and 23a country the 23a country and 23a c	erai	3934 2nd Street	20714	1	U.S.A
	teath tems er mu	ᆵ		3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
99	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 1 Yes 2 M No	1 ☐ Yes 2 🔀 No Specify:		Specify: White
0	hours natura ical E	lete	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b.	Kind of Business Industry
212	in 72 e. nan "r e Med	dw	Elementary/Seconday (0-12) College (1-4 or 5+)	ve kind of work done during most of work . DO NOT use retired)	ing	Name of Views
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Maryland 21215-0036	oe filed Intal H Ked ot Sever	10 B	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Nam	e (First, Middle, Maide	in Sumame)
ير	1 and 2 should be if Health and Men item 27 is marke other traumatic	1/	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip Code)
	d 2 sh alth a n 27 is ertrat		Albert Dowd / Husband P.C	Box 310, North B	each, MD 2	0714
ore,	0		20a, Method of Disposition 20b, Place of Di	sposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Ĕ	Page 1 ment of 1 tant: If it jury or o		4 🖫 Donation 5 🗆 Other (Specify) Anatomy			nover, Maryland
Baltimore,	permit. Page Department Important: I any injury or	Ų	21. Signature of Buneral Service Li ensee	22. Name and Address of Facility A 7522 Connelley Dr.		ts Registry Hanover, MD 21076
		\dashv	23a. Part 1. Enter the sisease, or complications that caused the death. Do not			Approximate Interval Between
	thysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastune โดยอินัก	- Clinces		Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			
	Examiner	r.	Sequentially list conditions, b.			
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury)			
A.	execut In and ial-trar	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
30	te be e nysicia ne bur	dical	d			
187	rtifical ing ph e as th	/Me	IF FEMALE 23c. If yes, outcome of pregnancy			and Data of delivery
ox e	ath ce attend for use	Physician/Me	in the past 12 months?	3 Ctopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Ď.	he dea y the a	hysi	1 Yes 2 No g Unknown			
P.0	that tined b		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		2 ☑No 3 ☐ Probably 4 ☐ Unknown
ds,	quires en sig ould b	ted			1 ∐ Yes	
CO	law re nas be	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Re	: The cate h			00 Pl	performed 1 Yes 2	No 1 🗌 Yes 2 🗆 No
ital	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Cher		6 ☐ Other (Specify)
of V	g Physer this leral di	e: To	27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c. Injury at	28d. Describe how in	
ono	ending sath. or: Afte	ficat	2 Accident Investigation	M 1 Yes 2 No		
Visi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occured at the time, date and place, a	and due to the cause(s) and manner as stated.
	n 24 h	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowled	nvestigation, in my opinion, death occurred ge, death occurred at the time, date and pla	at the time, date and place, and due to the cau	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.
	To the	-	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	ſ		106)	056029		January 31 2012
			30. Name and address of person who completed cause of death (Item 23a) (Ty Kenneth L. Albot 110 Hospital Road	DS6024 De, Print) Suite 110 Prince Fre	Lenck HD	20618
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi	ar	FEB 0 2 2012 Cener B. Sails			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Raymond D. Dow JAN 7:30pMedical 4c. County of Death Howard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elternhaus Assisted Living Dayton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1**X**□ M 2 □ F Months Hours Min JÄŃ Days 1924 210-14-4081 88 Pennsylvania Director Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗚 No Maryland Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 4201 Linthicum Road 21036 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U 14 Race - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No If Yes, Give 1942 Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 hours after Specify: White 1945 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Railroad Engineer Train Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ichabod Dow Beatrice Schiffbauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12212 Atherton Drive Silver Spring, MD 20902 Sarah Dow/wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/4/2012 Cedar Grove Mt. Morris, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 2. Name and Address of Facility Haight Funeral Home & Ch P.O. Box 195 Sykesville, Chapel Le, MD 21 aunce mc (410-795-1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atrial Fibrillation Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Medical Division of Vital Records, P.O. Box 68760 attending p for use as i use as IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Assisted 2 XNo Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Living ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? injury within 24 hours after death.

To the Funeral Director: Accompleted filled in by the fu death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physiolan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number

State

DHMH 17 Rev 7/2009

Registrar

6334 Cedar Lane #103

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Lazris, MD

2 2012

31. Date filed (Month, Day, Year)

FEB 0

D47447

Columbia, MD 21044

29d. Date signed (Month, Day, Year)

2/1/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edwana Medical Eacility Name (if not institution, or Location of Death 4c. County of Death Examiner Ltimone If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth (Month, Day, ge (In yrs. last birthday) **Funeral Director** 1 M 2 W 51 land 28a-f show 10b. County at Oa. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Director must be notified 1 Yes 2 No Maryland 10e. Street and Number 5 10f. Zip Code 10a. Citizen of What Count 713 23a Funeral items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Tes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Private life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o 2 Thomas Kelly Delores Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimor Butler-daughter Beller Terre Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory,

Mt. Zion 1 Burial 2 Cremation 3 Removal from State injury or Department Important: I any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Maryla. ever 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Her tolerin Sequentially list conditions, it can be be be cause. Enter Underlying Examine use as the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No jo Year Pregnant at time of death Month Dav been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director After this certificate has I autopsy performe 2 No 1 Yes or Attending Physician; 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

2

Walee Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30/2012

) anum

Battimore Mary Land 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 25, 2012 Antonio Fisher 12:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Paltimore 143 N. Patterson Park Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** (Month, Day, Year) 06/25/1967 Country) Maryland Days Hours 1 💹 M 2 🗆 F 214-78-4791 44 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at Director 1 XXves 2 □ No N/A **Paltimore** Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral United States 143 N. Patterson Park Avenue 21231 mit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Highway Maintenance Striper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold T. Fisher Victoria J. Smay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 N. Patterson Park Avenue Baltimore, Maryland Victoria Garcia - Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 又Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 01/27/2012 Atlantic Crematory Name and Address of Facility Lyid J. Weber Funeral Homes P.A. 11 S. Chester Street Baltimore, 21. Signature of Funeral Service Lic nsee Maryland 21231 Enter the disease, or comp k, or heart failure. List only on cations that caused the death. Do not enter Part 1 Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (o a a consequence of) if any, leading to immediate cause. Enter Underlying sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Yes 1 ☐ Yes 2 € 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No this certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 No ER/Outpatient 3 DOA မ 1 Yes 1 Inpatient 2 I 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After work? 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 Ann January 4:50 AM M Bridgette Famulari Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Wicomico Dove Point Salisbury Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, Funeral Days Hours 1 □ M 2 🔀 F 11*9*/1994/PB9884 216-11-5352 27 Mary Land Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Delmar Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8904 Mar Lynn Drive 21875 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc 1 X Never Married 2 Married Completed by Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Never Worked 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas A. Famulari, Sr. Mary Jane Curley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 N. Rock Glen Road Paltimore, Maryland 21229 Thomas A. Famulari, Sr./Father 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition New Cathedral 1 Burial 2 Cremation 3 Removal from State 02/04/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA Signature of Funeral Service Lice 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final mlmonam Chronic Obstructive Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Exami burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 L Yes 2 5 the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cerebral palsu 24a. Was an retardation performed? Yes 2 X No mental 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident☐ Sulcide Investigation 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completed filled in by the

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Anne Juntavin line 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00025316

January

405 Frederick Rd Sk 210 Catonsville, Maryland LANG MD Anne Dunlaven

State

DHMH 17 Rev 7/2009

4 Homicide

Christopher Follett	1- For Sta	te	Sta	te of Maryla		artment c		and	Menta	al Hyg		Reg. No.	20	12	026	7
Physician/		ent's Name (First									Date of De	ath	Year	3	Time of Death 0925 hrs	
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		tus Medical			mber y		Hagers					W	/ashingto	n		
Funeral	5. Social	Security Number	6	. Sex		. last birthday)	If Under		If Under Hours	24Hrs. Min.			IF.	oreian	lace (State or	
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the Maryland a or 28a-f sh tified at once Director		et and Number		T) * t.	D		10f. Zip C		7			10g. Citiz	en of What	Country	/?	
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Physician		Enter the dise re. List only one		omplications that c	aused the dea	th. Do not enter	the mode of	dying, s	uch as car	rdiac or r	espiratory a	rrest, sho	ck, or heart		Approximate Inter Between Onset a	
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit Be Completed by Physician/Medical Ex		ther algnificant	conditio	ons contributing to	o death but no	t resulting in the	underlying c	ause gi	ven in Par	t I.				_	e cause of death?	
S, P.(uires than n signed id be det	_										1 Y	es 2			psy findings availa	
Records, The law require: figate has been signage 2 should be Completed											auto peri	opsy formed?	pric		npletion of cause	
of Vital Records, P.O. og Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detact on: To Be Completed by F.	05.107						26	Place	of Death (Check on	1 Yes	2 N	0 1	✓ Yes	2 No	
Vital yricians this certi director	exam	case referred to iner? Yes 2		Hospital: 1	Inpatient 2	ER/Outpatie					Home 5	Reside	nce 6	Other:		
of \ ug Pby After th aneral calculation Teleforth	27 Mann	ner of Death		28a. Date	of Injury 1. Day Year) 2012	28b. Time o	f Injury 28		at Work?	I۹	8d. Describe		игу оссигтес	ī		
Sion Mtendi death. ctor: A sy the fi	1 N	Natural 5	Pendi Invest	igation		0112 hrs	and fortune		es 2	No			and Mumber	or Purs	I Route Number, C	City
Division o ppital or Attending tours after death. neral Director: Aft filled in by the func Certification:	3 🗌 s	Suicide 6	Could deterr	not be	be of injury - Al	t home, farm, st reet	eet, ractory, t	onice or	iliaing, etc		or Town	State)			Hagerstown, ME	
		y Certi	fying Ph	ysiclan: To the be	st of my knowl	edge, death occ	urred at the ti	me, dat	te and place	ce, and d	ue to the ca	use(s) an	d manner a	s stated	l.	
To the Ho within 24 To the Fu complete!	one)	2 ()		niner: On the basis and manner s		n and/or investig			number	curred at 1	tne time, da				h, Day, Year)	
A	296. Sign	nature and title o	r certifier	8	(IN)			O.C.N					uary 30,		,, Day, roar,	
n	30. Name	e and address of	person	who completed cau	ise of death (It	em 23a)								-		_
2	Meli	issa Brassel	, MD	Assistant Me	edical Exan	niner 900	W. Baltime	ore St	reet, Ba	altimore	e, MD 21	223			<u> </u>	
State Registra	4.5	filed (Month, Da	y, Ye <i>ar)</i>	32. R	egistrar's Sign	ature										
DHMH 17 Rev 1/2001		00M	/12	Leneva	p. 19	ORIGIN	AL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Deceden 's Name (First, Middle, Last) 2. Date of Death Month Ol Physician/ < VAU Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death De Birthplace (State or Foreign Country)
 MD If Und If Unde **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days Min. 1 - M 2 X F 07-02-1919^{ear)} 578-12-5464 92 MD Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD St. Mary's Lexington Park 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21412 Great Mills Road 20653 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. should be filed within 72 hours after of and Mental Hygiene.

is marked other than "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/200 conday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John White Narin, Sr. Ruth Virginia Lambert other traumatic permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Evans/granddaughter 7 Quiet Cove Trail, Panacea, FL 32346 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Cedar Hill Cemetery 02-03-2012 Suitland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility any 111hc Cedar Hill Funeral Home, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exami that initiated events Due to (or as a resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 46046 -2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amir N. Alikhani, MD PQ Box 1890, 101 Centennial Ave., LaPlata, MD 20747

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Gardner January 31, Day 2012 7:35 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number Sex XX M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye oct 2, 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 556-18-0216 California 89 **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD N/A Baltimore 5 4 1 1 XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Hawthorne Road U.S.A. 21210 12. Was Decedent Ever in U.S. Armed Forces?

**XXI Yes 2 No If Yes, Give WW II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No White 3 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Montgomery College 5+ (Pha) Professor Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Arthur Gardner Mable Rill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gardner (Son) 102 Hawthorne Road Balto, MD 21210 20a. Method of Disposition
1 ☐ Burial 2 AMCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crematory or other place; 2/6/12 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Tenss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licens 3631 Falls Road Balto,MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph. i.i.n Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of). Physician/Medical Exami Cause (Disease or iinjury anding physician and use as the burial-tran that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): certificate has been signed by the attending physician irector, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy Live Birth 2 🗌 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No ည ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 4 Nursing Home 5 Residence 27. Manner of De th 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 30. Name and and

ss of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of Dea	nth	,,,	g. No.		
Physici cal Exam		Decedent's Name (First, Middle,Last)	5 0-1	22116		2. Date of Death Month	Day Year	3. Time of Death 2335 hrs	
Cai LXaiii	mer	4a. Facility Name (if not institution, give stre		DRING T4b. City	, Town, or Location of Dea	January 28	4c. County of Death		
		55 A Lowergate Court		,	ngs Mills		Baltimore Cou		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. Ia	.,	nder 1 Year If Under 24		h(MM/DD/YYYY) 9. Bir		
Director		Unkn. 1⊠M	2□F 67	Yrs. Mor	ths Days Hours N	lin. 10/16	/1944 Foreig	n Azerbaijan umryzerbaijan	
any.		Usual Residence of Decedent 10a. State 10b. County	I10c City	Town or Location				10d. Inside City Limits	
*		MD Baltimo		Town or Education	Owings Mi	lls		1 Yes 2 No	
Aaryland 28a-f show Latones	Director	10e. Street and Number		10f. Z	ip Code	10	g. Citizen of What Cou		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland vent of Health and Mental Hygeins and the Maryland area of Health and Mental Hygeins and wastural", or items 23a, or 28a-f shown: If litems 72i markled other than "natural", or items 23a, or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.		55 A Lower Gate Court			21117		US	SA	
ith with tems 2 st be n	uneral		Was Decedent Ever in U. Armed Forces?		dent of Hispanic Origin? (cify Cuban, Mexican, Pue		14. Race - Amen White, etc.	can Indian, Black,	
ter dez	ш	3 Widowed 4 Divorced If Yes	Yes 2 No	1 Ves	2 No specify:		Specify:	White	
ours af atural	d by	or Date 15. Decedent's Education (Specify only hig	tes:	16a. Decedent's Usu	al Occupation (Give kind o		16b. Kind of Business/I	ndustry	
6 1.72 hc	lete	Elementary/Secondary (0-12)	ollege (1-4 or 5+) 5+		orking life. DONOT use r Delivery Person	etired)	Food /	Service	
withir withir Medi	Completed	17. Father's Name (First, Middle, Last)				(First 18:11)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natinjury or other traumatic event, the Medical Exa	Be C	Le	v Goldring		18.Mother's Na	Teinal Zeinal	aiden Surname) S Komachkova		
21, hould to id Men is mar	Tol	19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailing Addre	ss (Street and Number of	r Rural Route Numb	ber, City or Town, State	, Zip Code)	
MD and 2 shc alth and 27 is raumati		Lew Khodorkovsky / Frien Lev 20a. Method of Disposition		Place of Disposition (N	Village Court, Ba	Date Date		-	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Re		rematory or other plac Chesapeake Cr		2/1/2012	20c. Location - City or Reltsvi	lle, MD	
Itim it. Pa rtant y or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			nd Address of Facility	- 172012			
Ba Perm Depa Imp		21. Olyman State Control of the Cont		Maryl	and Cremation Se	ervices, PO B	OX 1413Baltin	nore, MD 21203	
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death.	Do not enter the mode	of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease a Athe	rosclerotic Cardiova				1	Death	
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	Jer	Sequentially list conditions,	(or as a consequence of	7):					
	Examine	(Disease or injury that initiated C	(or as a consequence of	·):					
ecuted and transit		d							
Division of Vital Records, P.O. Box 68760, Boopial or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Remeat Diversor: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical		#19a,per	FH,G924,2/	8/2012,WS				
876 tificate ng phy as the t	M/m	23b. Was decedent pregnant in the	If yes, outcome of pregr Live birth	nancy 2 Fetal deat	h 3 Ectopic preg	nancv	23d. Date of delivery Month	, Day Year	
Box 68's death certificate attending	Physician	past 12 months?	Pregnant at time of dea						
D. Be t the de by the	P.	Part II. Other significant conditions contr	Unknown	esulting in the underlying	no cause diven in Part I	23e Did tob	pacco use contribute to	the cause of death?	
i, P.O ires that t signed by	Ď	Diabetes			ig saddo givery iir aict		2 No 3 Prob		
Records, The law require ficate has been si page 2 should b	Completed					24a. Was a		topsy findings available	
eco he law te has	E					autops perform 1 ✓ Yes 2	ned? death?	completion of cause of	
tal Rection: The certificate	Be	25. Was case referred to medical			26.Place of Death (Chec			2 140	
of Vital ng Physician ther this certi	TO B	examiner? 1 ✓ Yes 2 No	i inpatient 2	ER/Outpatient 3	DOA Other Nurs	sing Home 5 F	Residence 6 🗹 Other	: Scene	
n of ding Pl After funeral			Ba. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred		
Division tal or Attendi rs after death.	gţ	2 Accident Investigation	90 Diago of Initiative At he	- form stood fort	1 Yes 2 No	006 1 1 (0)	- 19		
Divi	Certification:	Suicide Could not be	8e. Place of Injury - At ho Specify)	ome, raim, su eet, racto	ry, office building, etc.	or Town, Sta	treet and Number or Ru ate)	ral Route Number, City	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /		29a Certifier 1 Certifying Physician: To	the best of my knowledg	ge, death occurred at the	ne time, date and place, a	nd due to the cause	e(s) and manner as state	ed.	
To the Ho within 24 h	Medical		e basis of examination ar nanner stated.	nd/or investigation, in r	ny opinion, death occurred	d at the time, date a	nd place, and due to th	e cause(s)	
	Σ	29b. Signature and title of certifier	1 10	2	9c. License number		29d. Date signed (Mor		
	ļ	7 N			O.C.M.E.		January 29, 2012	<u>.</u>	
ļ	ļ	 Name and address of pers in who completed the service of person who completed the service of the s	eted cause of death (Item Medical Examiner	,	ore Street, Baltimor	e, MD 21223			
	ate	31. Date filed (Month, Pay, Year)	32. Registrar's Signatur						
Regis	rar	· ma A mair (TWW)	# 15 XEFEILS					1	

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State		Health and Mental Hygiene				00071				
	Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		Certificate	or Death	·	2. Date of Deat	eg. No.	116	3. Time of Death	
an/	Richard Michae						Month January	Day	Year	7:20 A M	
cai ner	4a. Facility Name (if not institution, give			4b. City, To	own, or Locatio	n of Death	odnodry	4c. County		7.20 11	
.0.	The Tate House			Lir	thicum			Anne	e Aru	ndel	
	5. Social Security Number 6. Se	7. Age	(In yrs. last bii	thday) If Under 1		er 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth Cour	place (State or Foreign	
	266-70-3454 Usual Residence of Decedent	™ 2 □ F	67	Yrs.			03/26/		111	inois	
5	10a. State 10b. County			n or Location						10d. Inside City Limits	
Director	MD Anne Ar	undel	Mill	ersville						1 🗌 Yes 2 🔀 No	
	10e. Street and Number			10f. Zip (Code		1	0g. Citizen of	What Cou	ntry?	
Funeral	516 Brightwood Ro				21108			U.S.A			
by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married 2 } \text{Married} \) Married 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes 2 } \text{X No} \)			If Yes, specif	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				ce - Americ ck, White,	can Indian, etc.	
q pe	3 Widowed 4 🗵 Divorced If Yes, Give Year or Dates.				1 ☐ Yes 2 🔀 No Specify:				Whi	.te	
Completed	15. Decedent's Ed (Specify only highest gra		16	a. Decedent's Usual	Occupation	ast of worki	na I	16b. Kind of B	usiness/Ir	ndustry	
To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. DO NOT use i	kind of work done during most of working OO NOT use retired)			Tng	70		
a l	17. Father's Name (First, Middle, Last)	4		Insurance		other's Name	Eirst Middle M		uranc		
[윤	Hyman William	Golub				18. Mother's Name (First, Middle, Maider Surname) Paula Gomberg					
	19a. Informant's Name/Relationship (T)		19	b. Mailing Address (State, Zip	Code)	
	Mark Golub / Son			516 Bright	wood R	oad, I	Millersv	ille,	MD 2]	L108	
1	20a. Method of Disposition 1	Removal from State	20b. Place cemet	of Disposition (Name ery, crematory or oth	of er place)	[Date	20c. Location	- City or T	own, State	
	4 X Donation 5 Other (Specif		Anaton	y Gifts Rec	istry		1/2012				
	21. Signature of uneral Service Licens	ee			Address of Fac		natomy G				
	23a. Part 1. Enter the disease, or com	olications that caused	The death Do				_		ver,	MD 21076 Approximate	
	shock, or heart failure. List only o	ne cause on each line	V V	n 1				- 1,		Interval Between Onset and Death	
i	disease or condition resulting in death)	a. Due to (or as a	o consequence	Iden	-4hc	21			-	1400	
.	0		,							,	
Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
xan	Cause (Disease or injury that initiated events c.									-	
I- I											
edic		d				•				·	
In/M	IF FEMALE: 23b. Was decedent pregnant	th 2 Estable of	T Estania prognancy			23d. Da	ate of deliv	very			
sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	5 Other (spe	Ectopic pregnancy Other (specify)				Month Day Year				
Phy	9 Unknown							4-16-14-4-4	She source of dooth?		
by	Farth. Other significant conditions c	luse given in r	2111				bably 4 X Unknown				
etec							24a. Was a			opsy findings available	
Completed							autops	sy med?	prior to co death?	ompletion of cause of	
To Be	25. Was case referred to medical				26. Place of D	Peath (Checi	1 L Yes	2 🔼 No	1 Yes	21 No	
	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 ER/0	Outpatient 3 DO	Othor			ence 6 🛣 Oth	ner (Specil	210 0	
	The impatient of the state of t										
I≝	4 Homicide determined	, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)					al Route Number,				
Sertific											
cal Certificate:	29a Certifier 1 Cartifying Phys	sician: To the heet of									
	(Check 2 Medical Exam		xamination and	Vor investigation, in m						ause(s) and manner stated s stated.	
Medical Certific	(Check 2 Medical Exam	iner: On the basis of e	xamination and	Vor investigation, in m	red at the time,	date and pla	ace, and due to th		manner as	stated.	
	(Check 2 Medical Exam only one) 3 Certifying Nur	iner: On the basis of e	xamination and	Vor investigation, in mowledge, death occu	red at the time,	date and pla	ace, and due to th	e cause(s) and	manner as	stated.	
	(Check 2 Medical Exam only one) 3 Certifying Nur	iner: On the basis of e se Practitioner: To th	xamination and	Vor investigation, in mowledge, death occu	red at the time,	date and pla	ace, and due to th	e cause(s) and	manner as	stated.	

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 0267	2	0	No. of Concession, Name of Street, or other party of the Concession, Name of Street, or other party of the Concession, Name of	2	0	2	6	7	-
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		1- For State Registrar	Certific	cate of Death		Re	eg. No.		
Physic cal Exam		1. Decedent's Name (First, Middle,Last) Frai				2. Date of Death Month Day Year January 28, 2012		3. Time of Death 1133 hrs	
		 Facility Name (if not institution, give street a 7940 Pulaski Highway 	nd number)	4b. City, Town, o Rosedale	r Location of Deat	h	4c. County of Deat Baltimore Cou		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Yea Months Day		_	th (MM/DD/YYYY) 9. Bir		
Director		213-66-7445 1 M 2] _F 41	Yrs.	73 Flodis IVI	March	14,1970 c	ountry) MD	
, any		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits	
Maryland 28a-f show d at once.	tor	MD Baltimore	<u> </u>		Edge			1 Yes 2 X No	
ne Mary or 28a fied at	Director	10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Cou United Stat	•			
with the ns 23a be noti	eral [8033 Wood Avenue 11. Marital Status 12. Wa	21 219 13. Was Decedent of Hispanic Origin? (Specify Yes of						
r death or iter	1 Never Married 2 Married Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Ricán, etc.)								
urs afte tural",	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates: Specify: Specify: Specify:							
36 thin 72 ho te. than "na	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)								
-003 within giene. ther th	omo	12 Years 2 17. Father's Name (First, Middle, Last)	lears	Welder	18 Mother's Nam	e (First Middle M	Welding Maiden Surname)		
21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be C	Frank M. Gasker, Sr	100			e L. Ald		The state of the s	
D 21 should and Me	To	19a. Informant's Name/Relationship (Type, Print) 1:	9b. Mailing Address (Stre 8033 Wood A				, Zip Code) L 219	
nore, MD 2 ages I and 2 shou nt of Health and N nt: If item 27 is n other traumatic		Janice L. Bowen (Mo 20a. Method of Disposition		of Disposition (Name of ce	0	Date Date	20c. Location - City or		
MOF6 Pages 1 hent of F int: If i		1 Burial 2 Cremation 3 Remo	vai il otti Otato	atory or other place) op Service Co	orp. 2/	2/2012	Towson, 1	Maryland	
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	1/1/1	22 Name and Addres	s of Facility Funeral	Home of	Dundalk,	Inc.	
?hysician		23a. Part I. Enter the disease, or complications to	hat caused the death. Don	7922 Wise				222 Approximate Interval	
Medical		failure. List only one cause on each line.						Between Onset and Death	
Examiner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated) Due to (or as a consequence of): Due to (or as a consequence of):								
a Control Country Last									
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Box 68 death certif he attending d for use as	So the state of the past 12 months? 1								
239. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									
SCOF te law r te has b ge 2 sh	24a. Was an autopsy performed? 1 Yes 2 No 1 N Yes 2							completion of cause of	
The state of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No Other Nursing Home 5 Residence 6									
f Vit Physici or this c	일	1 ✓ Yes 2 No		Outpatient 3 DOA			Residence 6 🗸 Other	: Scene	
ion of vertible to the total of the funeral the funeral of the fun	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending Fd 1-28-12 1 Yes 2 No 28d. Describe how injury occurred unknown							
Division of Vital rate or Attending Physician: Its after death. al Director: After this certiled in by the funeral directors.	Natural 5 Pending Investigation 3 Suicide 6 St Could not be determined Specify) found in motel room Natural 5 Pending Investigation 6 St Could not be determined Specify) found in motel room Natural 5 Pending Investigation 6 St Could not be determined Specify) found in motel room Natural 5 Pending Investigation 6 St Could not be determined Specify) found in motel room Natural 5 Pending Investigation 6 St Could not be determined Specify) found in motel room Natural 5 Pending Investigation 1 Yes 2 No Unknown Natural 6 Specify) found in motel room Natural 7 Pending Investigation 1 Yes 2 No Unknown Natural 7 Pending Investigation 1 Yes 2 No Unknown Natural 8 Pending Investigation 1 Yes 2 No Unknown Natural 9 Pending Investigation 1							ral Route Number, City	
Div To the Hospital or Within 24 hours afte To the Funeral Dir completely filled in									
thin 24 the Fu the Fu mpletel	dical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
F. W. S.	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
	O.C.M.E. January 29, 2012							2	
6		 Name and address of person who completed Jack Titus MD. Deputy Chief M 	, ,) 900 W. Baltimore Stre	eet, Baltimore	, MD 21223			
S	tate		2 Registres Signed						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Howard H. Hufnal, Sr. January 30, Physician/ 4:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Alice Manor Nursing Home N/A Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 7, 1940 Months Days Hours 1 💹 M 2 🗆 F MD' **Director** 71 221-26-6138 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must ha matified as 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XX es 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral | 2095 Rockrose Avenue 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: White Specify Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin Glenn Hufnal Anna Marie Gregg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Bolen (Sister) 3571 Abbs Valley Road Bluefield, Virginia 24605 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XX cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Atlantic Crematory 2/4/12 Glen Burnie, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Signature of Funeral Service Licenses 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronce disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Unknown neral Director; After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Certificate: To 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural 5 Pending injury work? Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D31464 31112 MD Name and address of person who completed cause of death (them 23a) (Type, Print) 5 ST SUIR 308 BATTIMONE MD 21201 SHOAII3

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

EB 0 2 2012 Leven A. Sav

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Herrines 2017 ecil KINWAYY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 XM 2□ F Months Days 12/09/1956 Director Maryland 216-72-5125 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 √Yes 2 No Director Sparrows Point MD **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Funeral 2122 Oak Road 21219 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Mill Crain Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Roy George Herring Margaret P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2122 Oak Road, Sparrows Point, MD 21219 Debbie Lynne Herring / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01.31.2012 Chesapeake Crematory 22. Name and Address of Facility Beltsville MD 21. Signature of Funeral Service Licensee Dorota Marshall

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Operation Services, PO BOX 1413 Baltimore MD 21203

Approximate Interval Between Operation Services, PO BOX 1413 Baltimore MD 21203

Approximate Interval Between Operation Services, PO BOX 1413 Baltimore MD 21203 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Call Conver to the Luns Metastatic Physician Sammous /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Directo (or as a consequence of) The law requires that tha death certificate ba executed attending physician and d for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No P.0. 9 Unknown the the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 No 2 🗌 No 1 Tyes 1 Tes certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Other: 4 I Nursing Home 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient ၉ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: hours after death. 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

11595

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Edward

31. Date filed (Month, Day, Year)

FEB U 2 2012

12-00843

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02678 State of Maryland / Department of Health and Mental Hygiene Thomas Johnson, Jr 1- For State Certificate of Death Reg. No Registrar
1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day January 28, 2012 1533 hrs Medical Examiner Thomas Johnson, Jr. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Dorchester Cambridge Dorchester General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Couldaryland Days Hours Min. Months 01/29/1964 Director 47 214-86-0118 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Cambridge or 28a-f show Dorchester "natural", or items 23a or 28a-f sho Examiner must be notified at once. Director hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21613 USA 726 Glasgow Street 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married Vac White Specify: 1 Yes 2 No specify: 4 Divorced If Yes, Give Yeer Ś 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nit. Pages 1 and 2 should be filed within 72 hour trment of Health and Mental Hyggene. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Truck Driver 9 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B. Ruth Nordberg Thomas Ray Johnson, Sr. 8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6426 Suicide Bridge Road, Hurlock, MD 21643 Larry Harrison / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I injury or other 2.3.2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Madical Death Narcotic (Heroin) and Quetiapine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g924 2-15-12 sm X UNPENDED attending physician or use as the burial Box 68760, 23d Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Š Cocaine Use Completed 24b. Were autopsy findings available 24a. Was en prior to completion of cause of autopsy certificate has performed death? 2 No 1 🗸 Yes ✓ Yes 2 No the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Other: 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification Natural unknown 1 Yes 2 X No 5 Pending the f hours after death. fd 1-28-12 fd 1450 hrs 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 726 Glasgow St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined Residence ambridge,MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 29, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimpre Street, Baltimpre, MD 21223 32. Reg 31 Date legy Man (2) (ear) State

DHMH 17 Rev 1/2001 OCME 2006

Registra

of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed this After Division within 24 hours after death.

To the Funeral Director: Director: I in by the f 10

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Medical

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Subject shot self 1 Natural FOUND: Pending 1 Yes 2 ✔ No Jan 28, 2012 1034 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 606 West Furnace Branch Road, Glen Burnie, MD determined (Specify) Residence 4 Homicide 29a Certifier 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year)

(Gr

O.C.M.E. January 29, 2012

30 Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar Signatur

Registrar

DHMH 17 Rev 1/2001

OCMF 2006

State

DEME

Death

Year

12-00708 Agnes Kincer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 02680 Certificate of Death 1- For State Reg. No. Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 25, 2012 0955 hrs **Medical Examiner AGNES** KINCER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Hours Months Country)Kentucky Director 1940 2 XF Mar. 14, 302-34-6184 1 M 71 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10b County 1 Yes 2 V No s 23a or 28a-f show e notified at once. Laurel MD Prince George's permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9000 Briarcroft Lane, Apt. 311 U.S.A. 20708 苬 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 4 XX Divorced If Yes, Give Year 1 Yes 2 XX No specify: Specify: White 3 Widowed ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Print Shop Hand Bindery 2 years 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Mildred Turner Ray Abbott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 672 Paddle Wheel Ct. W Millersville, MD Sheryl Neville daughter 20c. Location - City or Town, State Date 20b Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State W. Arundel Crematory 1/29/2012 Odenton, Maryland 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Avenue Laruel, Maryland 20707 M00770 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death /Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and certificate be executed Physician/Medical g physician a the burial -UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month 3 Ectopic pregnancy Day 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box (requires that the death 1 Yes 2 No 9 Unknown 9 Unknown ţ 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown 줊 ø. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy The law performed? death? certificate has ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other | Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28c. Injury at Work? 28h Time of Injury 27. Manner of Death Hospital or Atteoding | 24 hours after death. Struck by machine part UNKNOWN Natural 1 ✓ Yes 2 No Pending Jan 25, 2012 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 14830 Sweitzer Lane, Laurel, MD Suicide determined 24 hours a (Specify) Print shop Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 26, 2012 O.C.M.E. x o a 12 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 2

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			Registrar 1. Decedent's Name (First, Middle, L.	ast)		er timeate or E		2. Date of Dea		No.	3. Time of Death
	Physicia Medic	al .	Ernest H. Laude					Month 02/	01 2	Year 2012	6:52 AM [™]
	Examin	er	4a. Facility Name (if not institution, gi				Location of Death	of Death 4c. County of Death Baltimor			
Page C	Funeral		12323 Claydent 5. Social Security Number 6.		(In yrs. last birthda	Kingsv	If Under 24 Hrs.	8. Date of Birt	h		lace (State or Foreign
	Director		217 30 1301	1 X M 2 □ F	83 Yrs.	Months Days	Hours Min.		(Month, Day, Year) 12/03/1928		yland
	nd how at	<u>ا</u> ا	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location	1	12/03/	1320		0d. Inside City Limits
	/laryla 8a-f s tified	Director	MD Balti	more	Kingsv	ille					1 ☐ Yes 2 🛱 No
	h the la or 2 be no	al Di	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
	ith with ms 23 must	Funeral	12323 Claydent	Lane	verin IIS 1	21087	ispanic Origin? (Sp	ecify Yes or No-	U.S.A	ce - Americ	an Indian
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Completed by Fu	 11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced 	Armed Forces?		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Bla	ck, White, e	etc.
5-0	2 hour "natu edical	plet	15. Decedent's (Specify only highest		(Gi	cedent's Usual Occup ve kind of work done o	ation during most of work	king	16b. Kind of E	Business/Ind	dustry
121	within 7, giene. ner than t, the Me	Com	Elementary/Secondary (0-12)	College (1-4 or 5	+)	. DO NOT use retired) uck Driver			Gens	tar	
d 2	filed within al Hygiene. d other thai event, the N	Be	17. Father's Name (First, Middle, Las	t)		uck bliver	18. Mother's Nam	ne (First, Middle,			
ylar	should be file n and Mental F is marked o raumatic ever	임	Clarence Lauder	klos				Hurline	_		
Maryland	1 and 2 should be filed within 72 hour. Health and Mental Hygiene. Item 27 is marked other than "natur Item 27 is marked other than "natur other traumatic event, the Medical		19a. Informant's Name/Relationship Myrna L. Laude			ailing Address (Street a					
d)	ge 1 and t of Heal If item 2 or other		20a. Method of Disposition		20b. Place of Dis	sposition (Name of		Date	20c. Location		
mo	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			rematory or other place w Mem. Gdn		4/2012	Fallsto	on, Ma	ryland
Baltimore,	permit. Page 1 a Department of h Important: If ite any injury or ot once.		21. Signature of Funeral Service Lice	eral Taryla	Home, P.A. and 21087						
	4	П	23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause each line	the death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
يالت	Medical	0.0	Immediate Cause (Final disease or condition resulting in death)	a tros	tute (iancer	<u>ر</u>			_	Onset and Dewh
	Examiner		Positing in assum,	Due to (or as	a consequence of):						
4		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as				-			
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_	ate be executed ohysician and the burial-transit	edical E	resulting in death) cast	2001010100	a consequence of):						
3760	ficate g phys	Medi		_ d							
x 687	eath certifice attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc	ру			ate of delive	ery Day Year
Box	e deat the at ched fo	ysic	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 Other (specify)					
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	ne underlying cause gi	ven in Part I.				ne cause of death?
ds,	quires en sign	ted t						1 🗆	Yes 2 No	3 🗌 Pro	bably 4 🗌 Unknown
COL	law re as be e 2 sh	Completed						24a. Was auto		Were auto prior to co death?	psy findings available impletion of cause of
l Re	n: The ficate or, pag	e Col	25. Was case referred to medical	T = =		26 D	lace of Death (Che	1 Yes	2 No	1 🗌 Yes	2 UNO
Vita	nysician: The law I nis certificate has k I director, page 2 s	To Be	examiner? 1 \(\sum \) Yes 2 \(\beta \) No	Hospital:	ent 2 ER/Outpa	Oth	er.	lome 5 Resi	dence 6 🗆 Otl	her (Specify	·)
of	ding Phy h. After thi funeral	Ite:]	27. Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Da	ry 28b. Tim y, Year) inju	y worl	₹?	28d. Describe	how injury occur	rred	
ion	I or Attendi after death. Director: A d in by the fu	tifica	2 Accident Investigat 3 Suicide 6 Could no	t be	In/ - At home farm	M 1 L	Yes 2 No	28f Location 6	Street and Num	her or Rura	Route Number,
Division of Vital Records,	al or A s after I Direct	Ş	4 Homicide determine	building, et		direct, idetery, emee		City or Tov		00. 07. 10.0	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical Certificate:	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practitioner: To th	xamination and/or in	vestigation, in my opini	on, death occurred	at the time, date	and place, and d	ue to the ca	use(s) and manner stated.
	To th within To th comp		29b. Signature and title of certified	S	mo	29c. Licens Dee, Print) Let College	e number	827	29d. Date sign		
			30. Name and address of person wh	no completed cause of c	leath (Item 23a) (Typ	e, Print)	6		00		10 × =1011
			31, Date filed (Month), Day, Year)	Kels 5	ar's Signature	er Ullsaf	seave [X D	il Ce	1/	ND 21014
	Sta Registr		FFR 0 2 2		ar s signature	arlas					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 January 31, John Christian Larsen 4:25 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place N/A Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) August 1,1927 Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 381-24-2539 Hours 1**XX** M 2 \square F ountry) Michigan 84 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD N/A Baltimore 1XX Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 830 West 40th Street 21211 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Black, White, etc. "natural", or Completed by 1XX Never Married 2 Married 1 Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: White 3 🗍 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Doctor Library Sciences Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julius C. Larsen Bozena M. Blahnik 19a. Informant's Name/Relationship (Type, Print)
Thomas C. Cairns (Cousin) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 360 Bunker Hill Drive Brookfield, WI 53005 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Atlantic Crematory 2/3/12 Glen Burnie, MD 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. Signature of Fune/al Service Licenses Balto, MD 21211 3631 Falls Road 23a. Part 1. Enter the disease, or com **cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause out the line Immediate Cause (Final Physician/ arlunson disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Month ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, after death.

Director: After this certific

24 hours a Funeral L

within 2 To the F 14

State Registrar

Certificate:

Medical

5 Pending

Investigation

determined

6 Could not be

29c. License number 510

28c. Injury at

1 Vcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work?
1 Yes 2 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 ON

32. Registrar's Signature

28a. Date of injury (Month, Day, Year)

27. Manner of Death

Natural Accident

3 Suicide

29b. Signature and title of certified

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#11,18perFH, G924,273/2012, WS State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Year Physician/ 9:40a 31 Denise J. Ludlam Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours 53 058-56-8735 **Director** 1 🗆 M 2 💢 🖹 Yrs 10-26-58 NY Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at Director Westminster MD Carroll 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 23a 4047 Ridge Rd. 21157 USA death o Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Medical Examiner Armed Forces? Black, White, etc. ö þ 1 Davever Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: white "natural" Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Law the Legal Assistant Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)

Delores Scibelli th and Mental H 27 is marked of traumatic ever မ Joseph Ludlam 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2019 York Rd., Apt. 3, Gettysburg, PA 17325 Paula Ludlam-Cicero 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Park Cem. 2-4-12 Westminster,MD 4 ☐ Donation 5 ☐ Other (Specify) Muneral Service Licens 22. Name and Address of Facility Fletcher Funeral Home 21157 homas 254 E. Main St., Westminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CERVICAL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal occ.
Pregnant at time of death 3 | Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate I the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nufse Phactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohit Narana

Date filed (Month, Day, Year)
FEB 0 2 2012

20067468

CROSS roads Dr. Ste 340 Owings Mills, MO 2111

02-02-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ Lucich February 8:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1902 Monroe Road Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 9, 1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director New York 180-01-4688 1 M 2 XF 97 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Dundalk 1 Yes 2 X No Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21222 USA 1902 Monroe Road hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 8 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie Ivkouich Mark Sebal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1902 Monroe Road, Dundalk, MAryland Anthony Lucich son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 8, 2012 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Signature of Funeral S vice Liq Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. any M01176 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 he past 12 months? Yes 2 2 No Month Year 5 Other (specify) Pregnant at time of death signed by the a Id be detached 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown been signature beautiful b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has it autopsv performed 1 Yes 2 No this certificate 25. Was case referred to medical examiner?

1 Yes 2 Alo Division of Vital 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) Residence 6 \(\text{Other} \) Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certific 29c. License number 30555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7586 Work 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# I per PHYS, G924, 2/7/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2
amend #5 Per FH G925, 3/07/2012, JH
Certificate of Death H 1 - State Registrar 1. Decedent's Name (First, Middle, Last) Louis Arnold Lolli 2. Date of Death 3. Time of Death Physician/ January 2012 5:45am [™] Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Ye March 10 Birthplace (State or Foreign Country)
 MD 5. Social Security Number **34** 217–30–4062 If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday **Funeral** Hours 1 XM 2 □ F Months MD 74 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Carro11 Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2021 #1A Rudy Serra Drive 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Revenue Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnoldo Lolli Anna Valianti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 Collier Court, Westminster, MD 21158 Mr. Dino Lolli (Son/Executor) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2/3/2012 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 400764 23a. Part 1. Enter the disease, or complicati th. Do not enter the mode of dying, such a Approximate shock, or heart failure. List only one car Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ig physician and as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant bonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 3 Probably 4 Unknown 2 🗌 No 1 🗌 Yes cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 INO 1 Yes 2 🗚 To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spe 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 3 28d. Describe how injury occurred Certificate: 28c. Injury at ☑.Natural 5 Pending work? 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier

Registrar

State

31. Date filed (Month, FEB 0 2

17

292 Stoner Ave, Westminster, MD 21157

ho completed cause of death (Item 23a) (Type, Print)

32. Regis 'ar's Signature

Kruten

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	arylan	-	ertificate of				_ ,	2012	2 02686
i	Physicia		1. Decedent's Name	(First, Middle, Last	eanwel	1					2. Date of De Month	ath Day	2012	3. Time of Death 9:45 A M
	Medic Examin		Aa. Facility Name (if	not institution, give	street and number)	Me	1.16	4b. City, Town			unie	4c. Co	ounty of Deatl	
	Funeral Director		5. Social Security Nu 577–52–4683	ımber 6. Se	Shington X 7. Age IM 2 Top	(In yrs. la	ist birthday) Yrs.	If Under 1 Yes Months Day	ar If Unc	der 24 Hrs.	8. Date of Bir	th		hplace (State or Foreign untry)
		_	Usual Residence of 10a. State				, Town or L	ocation			00 10	1,01		10d. Inside City Limits
	//arylar 8a-f si tified	Director	MD	Anne Arund	el	Crof		ocation						1 X Yes 2 No
	th the l 3a or 2 t be no	'al Di	10e. Street and Num 1707 W. Ban					10f. Zip Cod				_	n of What Co	untry?
	eath wi tems 2 er mus	Funeral	11. Marital Status	Tort raile	12. Was Decedent E	ver in U.S	i. 13.	21114 Was Decedent o	f Hispanic (Origin? (Spe	ecify Yes or No-	USA 14.	Race - Amei	rican Indian,
9030	ırs after d ural", or i Il Examin	by	1 Never Marrie		Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates.	No		If Yes, specify Cu 1 ☐ Yes 2 🕅			Rican, etc.)	Spe	Black, White ec <i>ify:</i> Whi	
215-(יסו 72 הסו an "nat Med ica	Completed		15. Decedent's Ed	de completed)		(Give	edent's Usual Occ e kind of work dor DO NOT use retire	e during m	nost of worki	orking 16b. Kind of Business Industry			Industry
121	d withir lygiene lher th nt, the	Be Co	Elementary/Seco 12th		College (1-4 or 5	+)	Secr	etary					1 Gover	nment
/land	d be file Mental H arked of	To B	17. Father's Name (F Kenneth A.							other's Nam tha E.	e (First, Middle, Larson	Maiden Sun	name)	
, Man	id 2 shoul salth and I n 27 is ma er trauma	35	19a. Informant's Na James DiCa	me/Relationship <i>(Ty)</i> rlo, Jr./so	•			ling Address (Stre W. Bancrof						Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Department of Health and Mertall Hygiene. Inportant: If item Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2 4 Donation		Removal from State	C C	emetery cre	osition (Name of ematory or other p Pk Cremato	lace) ry	02-01-	Date -2012		tion - City or ale Par	
Balt	permit. Departs Import any inji	12	21. Signature of Fun	eral Service License	ee .		3	22. Name and Add Cedar Hill	FH, 4	cility 111 PA	Ave.,Sui	tland,	MD 2074	6
ı			3a. Part 1. Enter the shock, or heart Immediate Cause (F	t failure. List only on	lications that caused e cause on each line	the death	n. Do not en					тest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)		a. Due o (or as a	consequ	ence of):	Puer	uno	nia				week
	Examiner	Jer	Sequentially list cor	nditions, mediate	b. — Due to (or as a	consequ	ence of):							
В	cuted ind transit	xamir	Cause (Disease or in that initiated events	lying injury	C									
0	cate be executed physician and the burial-transiti	edical Examiner	resulting in death) L	ast	Due to (or as a	consequ	ence of):							
9280	rtificate ing phy e as th		IF FEMALE:										1	
Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent print the past 12 mm 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	23c. If yes, outcome of 1 ☐ Live Birth : 4 ☐ Pregnant at g ☐ Unknown	2 🗌 Feta	I death 3	☐ Ectopic pregna☐ Other (specify)				230	d. Date of del Month	ivery Day Year
P.O.	requires that the de been signed by the should be detached	by	1	_/ \ /	ntributing to death bu	ut not resu		underlying cause	given in Pa	art I.	23e. Did t			the cause of death?
ords,	require been si should b	leted	rhoume	c (0/ at	ar (ur	771.	>				1 🗆 24a. Was			robably 4 Unknown
Division of Vital Records,	rsician: The law s certificate has b lirector, page 2 s	Completed									. auto		prior to death?	completion of cause of
ital	ician: certific rector,	Be	25. Was case referre examiner?		lospital:			T-	Place of D	Death (Check				
of V	ng Phys ter this neral dii	te: To	1 Yes 2. 27. Manner of Death	TNO	28a. Date of injur (Month, Day	у	ER/Outpation 28b. Time of injury	of 28c. In	4 🗀		me 5 🗌 Residente 128d. Describe 1			ify)
sion	Attendir death. ctor: Af y the fu	Certificate:	2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not be				M 1	Yes 2		28f Location /	Stroot and N	umbor or Pu	ral Route Number,
ΟX	iital or / urs after ral Dire		4 🗌 Homicide	determined	building, etc	. (Specify))				City or Tov	vn, State)		, , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page:	Medical	(Check 2	Medical Examir	ician: To the best of o er: On the basis of ex e Practioner: To the l	amination	and/or inve	stigation, in my op	inion, death	n occurred at	the time, date a	and place, an	d due to the o	cause(s) and manner stated.
	To the with To the com		29b. Signature and t	itle o certifier	allen.	M	D.	29c. Lice	nse numbe	40		_	igned (Month	- 1-
	5		80. Name and addre	se of person who co	ompleted cause of de	eath (Item	1	Print)	Dain	10 1	Slen	R	rain !	29,2012 4021061
E	Stat Registra		31. Date filed (Month	2012 L	32. Registra	r's Signat	ure	.,,	/ 1 . 0		7	1,) (1)	vile / 1	0100/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 February 1:57 D. Myrick Katherine Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Parkton 4 Prettyboy Garth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Davs Hours 126-34-6811 Director JAN 31, 1942 New York 70 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director 1 Yes 2 X No MD Baltimore Parkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21120 USA 4 Prettyboy Garth or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 X Married þ 2 **X**No Yes 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) the Printing Typesetter Graphic Artist Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, tonce. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Distefano Titolo Michael Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parkton, MD 4 Prettyboy Garth John A. Myrick, husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1
Burial 2
Cremation 3
Removal from State Metro Crematory, Inc. 02/02/12 Baltimore, MD 4 Donation 5 Other (Specify) MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George 21228 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pup ici n disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to or as a consequence of than y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events tending physician and ruse as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE been signed by the altendin should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 **X**No 3 Probably 4 Unknown Completed KATHERINE . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death?
1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 \sum Yes 2 \sum No Investigation 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20T2 12:55 AM John Rodney May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F July 25, Year) Months Days Hours Min. Mary Land 81 **Director** 213-30-661 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location notified at Director 1 🗆 Yes 2 🔀 No E1kton MD Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 2 should be filed within 72 hours after death with the thit and Mental Hygiene. 27 is marked other than "natural", or items 23a on traumatic event, the Medical Examiner must be. Funeral USA 21921 28 Oak Tree Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1947 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2X No Specify: 1954 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 auto assembler automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Washington May Mabel May Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st:
Department of Health an
Important: If item 27 is
any injury or other trat Rebecca May - wife 28 Oak Tree Lane; Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify) Funeral Service 22. Name and Address of Facility State Anatomy Board Ronald 655 W. Baltimore St; Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shoc Immediate Cause (Final disease or con it in resulting in death) Onset and Death Ph_sician/ COPD Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last ending physician are use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes s been signature should be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s To the Hospital or Attending Physician: The law autopsy perform death? certificate l 1 🗌 Yes 2 🗆 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No ည 1 X Inpatient 2 DER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical

State Registrar 29a. Certifier

(Check

only one)

29b. Signature and title of califie

HERMAN HWY 2533 AUGUSTINE ranke

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAW

K certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0062190

12

SUITEX, CHESAPEAKE CITY, MD21915

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 9:15 A M Gloria P. McCarthy January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Harmony Hall Assisted Living Columbia 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6. Sex Country) **Funeral** Days Hours 1 □ M 2 🗓 F 3/10/1928 83 138-30-4297 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Tes 2 No MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 USA 6336 Cedar Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Mamed 2 Married 1 Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1st Grade Teacher Public School System 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic en John Pasino Carrie DeFelice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Alicea / Daughter 20002 Hickman Way, Poolesville, Maryland 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State Middletown, NJ Fairview Cemetery 1/28/2012 4 Onation 5 Other (Specify) 21. Ignature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Renal Failure Phy i i n/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Uncernying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 XNo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47447 1/25/2012

DHMH 17 Rev 7/2009

State

Registrar

Cedar Lane, 103, Columbia, Maryland 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6334

Andrew Lazris
Data filed (Month. Day, Year)

FEB 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02690 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2012 Physician/ Mekolon, Sr. Robert John 9:24P Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Dundalk 95 Delmar Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs Hours Mir (Month, Day, Year) **Director** 218-36-5333 1 **X** M 2 □ F Yrs March 10,1941 Maryland 70 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified MD 1 Yes 2 X No Dundalk Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ural", or items 23a or Examiner must be Funeral 21222 United States 95 Delmar Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 'natural", 3 X Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Years Industrial Engineer Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fint of Health and Mental it fitem 27 is marked 2 Emma Nemcek Adolph Mekolon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3315 McShaneway Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mr. Michael S. Mekolon(Son) 3315 McShaneway Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Lutheran Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State injury or 2/1/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Buda-Ruck Funeral Home of Dundalk, Inc. any 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami physician and the burial-transit death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Physician/Medical IE EEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy certificate 1 Tes 2 No the Hospital or Attending Physician: bin 24 hours after death. the Funeral Director: After this certific ripletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniun Natural 5 Pending work? 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Signa

68760

Box

P.0.

Records,

DHMH 17 Rev 06-2011

PHYADELPHIARO

MO

29c. License number

29d. Date signed (Month, Day, Year)

SUITE 200 Bolt MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 26 9:25 January Lester Gerald Newcomb Jr. Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1347 James Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min **Director** 214-38-1911 1 X M 2 □ F 71 26, 1940 Maryland 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21223 1347 James St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 12 paper cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jenny Barnabei Lester Gerald Newcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 James St; Baltimore, MD 21223 Paula Pelsinski - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board peral Service 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ DISRAS oranaru ARTEVEL LA disease or condition Medical resulting in death) Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed after death.

Director: After this certificate | 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔊 Residence 6 Other (Specify) ၀ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

512 Harfer-

29c. License number

Rd

R106862

North Parkville

29d. Date signed (Month, Day, Year)

2012

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ Marjorie Catherine Ordun 2012 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy . Social Security Numbe If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours January 15, 1928 315-18-1094 Nebraska 89 Director Usual Residence of Decedent show or 28a-f shov notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 🕅 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ò must be r Funeral 5955 Quince Orchard Rd. 21704 United States items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No er than "natural", or iter the Medical Examiner 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LeRoy Spencer Paulsen Emma Minnie Lizzie Krist 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 St. Dunstan's Rd. Michael Ordun/son Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory Jan. 31,2012 4 Donation 5 Other (Specify) Baltimore, Maryland Mitchell-Wiedereld Funeral Home, Inc. Signature of Funeral Service Licenses 6500 York Rd. Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 use as attending IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 🗆 Unknown 9 Unknow Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? certificate ! 1 Yes 2 No 1 Yes 2 XXVIII 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: Natural 5 Pending work' s after death.

I Director: Aff
d in by the fur 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined nin 24 hours af the Funeral Di npleted filled ir Medical 29a. Certifier 1 K Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple 29b. Signature 29c. License number 68

State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia		Malling Inst, wilder, La	e. PRIC	e			ay Year 27.2019	3. Time of Death
	Medic Examin		4a. Facility Name (if Not institution, giv			Location of Death		c. County of Death	4 / 1
1	LAGIIIII	Ç.	4825 Midw	ood Ave	Bu	Ho.			
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. Ia	Months Davs		Date of Birth (Month, Day, Year)		place (State or Foreign
Н	Director		731-20-2001	5	3 Yrs.		9-9-19	128 VIE	G1114
	nd how at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	laryla 3a-f s ified	Director	Mol		Balto.				1 Yes 2 No
	or 28 e not		10e. Street and Number	. 0 1	10f. Zip Code		10g. C	citizen of What Cou	intry?
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Funeral	4825 Midi	wood Ave	2/	212		USI	17
	item item		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify an Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Ameri Black, White,	
36	after (", or kamii	d b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☐ No	Specify:		Specify:	acic
21215-0036	atura cal E	Completed	15. Decedent's	Year or Dates.	16a, Decedent's Usual Occup	ation	16h	Kind of Business Ir	ndustry
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212	within giene. er thar the N		Elementary/Seconday (0-12)		Supera	VISOR	A	duins	tration_
pu	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)		V	18. Mother's Name (Fil			
yla	Ild be I Menta narked natic e		Joseph W	, 15D	<u></u>	CORA	Syle		277~7
Maryland	12 should lith and M 27 is mai		19a. Informant's Name/Relationship (The contract of	19b. Mailing Address (Street	and Number or Rural Ro	oute Number, City o	r Town, State, Zip	Code) ///53
	and healt		20a, Method of Disposition	RRY 20b. F	Place of Disposition (Name of	Date	20c.	Location - City or 1	own, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 [Removal from State	cemetery, crematory or other place AYVIEW CHEMI	ce) .	0/12	Balto.	mel.
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			23a Part 1. Enter the disease, or cor shock, or heart failure List only	nplications that caused the deat	th. Do not enter the mode of dyin	g, such as cardiac or re-	spiratory arrest,		Approximate Interval Between
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	Medical Examiner		resulting in death)	Due to (or as a consequ					
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80	endin r use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy al death −3 □ Ectopic pregnan	су	ļ	23d. Date of deli	
B 0)	death he att ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of a ☐ Unknown	death 5 Other (specify)			Month	Day Year
P.O. Box 687	requires that the death certific been signed by the attending i should be detached for use as		Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause gi	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
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rd	requi been should	ete	il las de m	dema			24a. Was an	24b. Were aut	opsy findings available
ecc	e law e has ige 2	ğ	superico				autopsy performed?	death?	ompletion of cause of
E E	an: Th tificat tor, pa	Be C	25. Was case referred to medical		26. P	lace of Ceath (Check on	1 ☐ Yes 2 ☐ Iy one)	¶o 1 □ Yes	2 No
Vita	ysicia is cert direct	To B	examiner?	Hospital:	ER/Outpatient 3 □ DOA Oth	er: 4 🗌 Nursing Home	5 ☑ Residence	6 ☐ Other (Speci	fy)
ð	ng Ph ter th neral		27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time of 28c. Injury work	y at 28d	. Describe how inju	ury occurred	
ion	eath. or; Af the fu	iji	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	he	M 1 [Yes 2 No			
Division of Vital Records,	or Att	Certificate:	4 Homicide determined		ome, farm, street, factory, office (y)	28f.	Location (Street a City or Town, Star	and Number or Run te)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Ph	vsician: To the best of my know	vledge, death occured at the time	e, date and place, and d	ue to the cause(s)	and manner as sta	ted.
	e Hos 24 h e Fun leted	Medical	(Check 2 Medical Exam	niner: On the basis of examination	on and/or investigation, in my opini ny knowledge, death occurred at the	on, death occurred at the	time, date and place	ce, and due to the c	ause(s) and manner stated.
	To the within To the Comp	2	29b. Signature and title of certifier		29c. Licens			ate signed (Month	
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	3		30. Name and address of person who		m 23a) (Type, Print)	0242.			2.
			Ursula McChy	- 17		1 St - BC	eltimore	e MO	21224
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 2012	32. Registrar's Signa	ature				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PRASCUS Physician/ Month ALBINAS 2012 6:13 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1/1/1921 Director 215-30-3129 Usual Residence of Decedent 1 🔀 M 2 🗆 F 91 Lithuania or 28a-f show e notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🗙 No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a o , the Medical Examiner must be Funeral 1107 Plover Drive 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lab Tech. Food Industry and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Page 1 and 2 should be f. Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Jurgis Prasciunas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kestutis J. Prascus / Son 1906 Bayside Drive, Chester, Maryland 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Loudon Park Cemetery 1/30/2012 Baltimore, Maryland 21 Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of ig physician and as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical SULTENT DISPASE P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Unknown signed by Part II. **Other significant conditions** contrib<u>u</u>ting to death but not re<mark>a</mark>ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident (Month, Day, Year) 5 Pending work?
1 Yes 2 No M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a: Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of D0062395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS 406 ADMINAL DYIVE + A COUMAR State FEB 0 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 02 2012 **Physician** 8:35 A^{M} Stanislava Rasic /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Clarksville 12737 Chapel Chase Drive 8. Date of Birth (Month, Day, If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** 1□ M 2🏋 F Months Days **Croatia** 08/31/1930 81 218-71-5963 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State or items 23a or 28a-f show, permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1 XYes 2 No Director Clarksville MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21029 **USA** 12737 Chapel Chase Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify. Specify ģ 3 XWidowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Finance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vilim Jurac Josipa P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dubravka Casario / Daughter 12737 Chapel Chase, Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Na Cremation 3 ☐ Removal from State 2/2/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lung Cancer disease or condition resulting in death) lyear londing /Medical Due to (or so consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the attending physician and ned for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ye ar 5 ☐ Other (specify) n signed by the a Id be detached fo ☐Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown tor: After this certificate has been so the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No 2 🗆 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 점 Residence 6 ☐ Other (Specify) Hospital: 1∐Yes 2K∭No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funeral L hours a Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DC023601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Drive, Suit GOZO 31. Date filed (Month, Day, State FEB U 2 2012 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Year $\mathsf{J}^{\mathsf{Month}}_{an}$ 7:45P M John Charles Radcliffe 30 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Days Months Hours 7-7-1937 219-32-7209 74 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Westminster 1 🗆 Yes 2 🖎 No Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21157 2136 Old Westminster Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specifywhite If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Matthews Charles E. Radcliffe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 19a. Informant's Name/Relationship (Type, Print) 2136 Old Westminster Pike, Westminster, MD Joyce Radcliffe-wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Westminster, MD Meadow Branch Cem 2-3-12 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home Signature Juneral Service Licenses E. Main St., Westminster, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. 1

Physician/ Medical Examiner

use as the burial-transit

and

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

or items 23a

ge 1 and 2 should be filed within 72 hours after dea nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner

permit. Page 1 a
Department of h
Important: If ite
any injury or ot

Baltimore, Maryland 21215-0036

must be notified at

Director

Funeral

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Completed

Be

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MD

filed within 72 hours after death with the Maryland

Be Completed by Physician/Medical Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After the funeral director, page 2 should be detached for use as the burial Certificate: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of):							
that initiated events resulting in death) Last	Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year					
Part II. Other significant conditions cont	ributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown					
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)						
1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specify)					
27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred					
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)					
(Check 2 Medical Examine	ian: To the best of my knowledge, death occured at the time, date and place, an r: On the basis of examination and/or investigation, in my opinion, death occurred at Practioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place	e, and due to the cause(s) and manner stated.					

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Comano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4023 Colchester Road, Apt. 212 Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) Days 1 🔀 M 2 🗆 F Months (Month, Day, Year) 02/19/1960 **Director** 220-68-5666 Maryland Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Baltimore City MD 6 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 21229 4023 Colchester Road, Apt. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 M Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No "natural", 3 Widowed 4 Divorced White Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Je filed wn.. *al Hygiene. '`er than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction should be filed with and Mental Hygien 7 is marked other ti Drywall Hanger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nancy J. Linn Vincent Romano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health a Important. If item 27 is any injury or other tra once, 4023 Colchester Rd, Apt. 212, Baltimore, MD 21229 Michele Conaway / Fiance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3, ☐ Removal from State 01/31/2012 Hanover, Maryland Anatomy Gifts Registry 4 Donation 5 Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Ligensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month completed filled in by the funeral director, page 2 should be detached Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 Probably 4 Unknown Completed 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform thin 24 hours after death.

the Funeral Director: After this certificate the Hospital or Attending Physician: ' Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 0 D185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ton 32. Registra 's Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ,2012 January 4:15P4 Jane Sanford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 2905 Conroy Court Apt. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day, Year) **Director** 220-30-6119 1 □ M 2 💢F 92 March 31.1919 New York ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Parkville Maryland 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21234 **USA** 2905 Conroy Court Apt. . Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No 19 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 1944 1946 Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ William Wells Sanford Ida Barbara Kroeger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 s Health a 2911-A Conrov Court Parkville, Maryland 21234 Joann M. Burton, Executor Baltimore, item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 02/01/12 Baltimore, Maryland Signature of Funeral Servi Lic hse Thomas Gregor emation Society Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final **Physician** YEUVS Medical resulting in death) , Examiner Sequentially list conditions, if any, leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami ending physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Yes 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/4 St. Kaul St. Paltimor

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 12:30 PM 01 -26-2012 Physician/ JOSE PH EUGENE Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** Baltmore Center attimore medical VA Birthplace (State or Foreign Country) 8. Date of Birth . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. (Month, Day, Year) Min **Funeral** 207-40-272 Months Pennsyl vanit 9-8-195 1 M 2 D F **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director ARLINGton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15 A 74 22209 Street Apt Funeral 800 N. 16 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: by Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Auto Care Detailing Cars College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname, Be 17, Father's Name (First, Middle, Last) ည UKn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22205 19a. Informant's Name/Relationship (Type, Print) Triend 3000 Sport Run Parkway 1) 601 Atlington Va. Michelle Smith 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory Date Baltimore, 20a. Method of Disposition Bulto. Md 28 12 gremation 3 Removal from State 1 🗌 Burial 2 🗷 5 Other (Specify) Mers Metropolitan Chapel 4 Donation 22. Name and Address of Facility Funeral Service Licensee . Signature Barto Md. lela any 1639 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebovascular Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed, within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery IE EEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Month in the past 12 months? 4 Pregnant at time of death
9 Unknown 1 ☐ Yes ∠ □ g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed by Diabetes Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital 1 Impatient 2 ER/Outpatient 3 DOA 2 No မ 28d. Describe how injury occurred 28c. Injury at work? 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 3 Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie only one) 29d. Date signed (Month, Day, Year) Tracy Timmons 29b. Signa 01-26-2012 D002116 M.D

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State

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22

32. Registrar's Signature

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timmons

IRACI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 19a-b, per fh, g925 3-19-12 sm
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Mary		tificate of D			Reg. No. 2	112	02700
	Physicia		1. Decedent's Name (First, Middle, Las					Date of Dea Month		Year	3. Time of Death
	Medic	al	Vera Ellen Sube			4h City Town or	Location of Death	van	Day 28 2 4c. County	of Death	01 45AM.
	Examin	er	St. Agnes			BALTIM			40. County	or Death	
8	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Da Oec 15,	th y, Year) 1955	9. Birthpla Country	ce (State or Foreign unk
	and show at		10a. State 10b. County	10	c. City, Town or Loc	cation				100	d. Inside City Limits
	Maryla 28a-f stified	irect	MD		Baltimo	re					1 X Yes 2 No
	s 23a or and the nust be no	Funeral Director	10e. Street and Number 5049 01d Freder	ick Ave.		10f. Zip Code 21229			10g. Citizen of V USA	Vhat Countr	y?
9800	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾	11. Marital Status 1 ፟X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates.	1	f Yes, specify Cubai		cify Yes or No- Rican, etc.)	Blac Specify:	e - Americar k, White, et blacl	c. K
215-(iin 72 hou ie. han "nat	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	(Give I life. D	O NOT use retired)	ation luring most of worki	ng		Price	e Jones
121	Hygien Hygien other t	l as l	12 17. Father's Name (First, Middle, Last)	2 unk	tea	acher	18. Mother's Name	e (First, Middle,			t Center
land	be filed lental Hy rked oth tic event	인	John Suber	GIFTE					e Chapma		
lary	should be fill and Mental 7 is marked or raumatic eve	- 3	19a. Informant's Name/Relationship (7				and Number or Rura				de)
°,	and 2 stealth		Jennifer Legge Danielle L. Pop 20a, Method of Disposition		20b. Place of Dispo	Seagull Blue Jay		ethorp	20c, Location -		n State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		1 ☐ Burial 2XX Cremation 3 ☐ 4 ☐ Donation 5 XX Other (Special Control of the Con	Removal from State	Onsite	natory or other place Crematory	02/02	/2012	Baltimo	ore,M)
Ball	permit Depar Impor any in		21. Signatur, or runeral Service I cen	if ect			Brown y Sta Baltimore			Fults	n Aye
	Physician/		23a. Part Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	e death. Do not ente		g, such as cardiac c	r respiratory ar	rrest,	100	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	aDue to (or as a co		36 03/3					INCOL
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):						
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events	cDue to (or as a co	programmo of:						
200	cate be executed physician and sthe burial-transi	ledical E	resulting in death) Last	d	misequence oi).						
Box 68	death certifi ne attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ¥60 9 ☐ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin	Fetal death 3	Ectopic pregnand Other (specify)	гу			ate of deliver	y Day Year
s, P.O.	res that the signed by the		Part II. Other significant conditions of	contributing to death but r	not resulting in the u	underlying cause giv	ven in Part I.		tobacco use cont		e cause of death?
Division of Vital Records,	Physician: The law requires this certificate has been signral director, page 2 should be	Completed by							psy ormed?	Were autop prior to com death? 1 \(\subseteq \text{Yes} \)	sy findings available upletion of cause of
ta	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	Hospital:			ace of Death (Chec	k only one)			
ίV	Physic this c	요	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatie		4 ☐ Nursing Ho		idence 6 Oth		
o u	Attending or death. ector: After by the funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye		work	Yes 2 No	200. 00001100	now injury occur		
ivisio	of or Attender after deal	Certificate:	3 Suicide 6 Could not 4 Homicide determined			reet, factory, office			(Street and Numb wn, State)	er or Rural I	Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the pompleted filled in by the funeral	Medical	(Check 2 Medical Exan	ysician: To the best of my niner: On the basis of exam rse Practioner: To the bes	nination and/or inves	stigation, in my opinio	on, death occurred a	t the time, date	and place, and du	e to the cau	se(s) and manner stated.
	To the I within 2 To the I comple	2	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	d (Month, D	ay, Year)
	(Sishar		MD.		25482		Jan	28	2012
_	(8)	1	30. Name and address of person who	Shrestha	900 5	caton	Ave	MD 2	21229		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 2 201	2 Central's	Signature	KI					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Clara E. Spielman Physician/ Month Day 4:15 P January_ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium Age (In yrs, jast birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth MD Country) **Funeral** Feb 5, 1921 1 M 2 XX 219-20-7698 Director Usual Residence of Decedent show or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director MD Baltimore 1 ☐ Yes XX No Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō event, the Medical Examiner must be Funeral 23a 1824 Notre Dame Avenue 21093 U.S.A. or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give þ Baltimore, Maryland 21215-0036 XX No Specify "natural", 3XX Widowed 4 Divorced White Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest E. Peterson Susan Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Spielman (Son) 1824 Notre Dame Road Lutherville, MD 21093 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Oaklawn Cemetery 1XXX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/12 Baltimore, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Signature of Femeral Sep/Ice Licensee BAlto. MD 3631 Falls Road 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final -Fhyuician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last 2012, Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the decivithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy SPIELMAN 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28b. Time of 28a, Date of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending **Division** 1 Yes 2 No Μ 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

JANUARY

31. Date filed (Month, Day, Year)

30. Name and address of person who comple JUSTINE PREIS, CRNP

29b. Signature and title of certifier

(Check

32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

R043580

2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

01-31-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Day, 2012 Physician/ Frances Eleanor Smith 10:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville 6112 Moorefield Road If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2XXF Days Hours 02/16/1932 Maryland 79 Director 215-28-9815 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21228 6112 Moorefield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: "natural", Completed 3XWidowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Cashier Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Frances Loretta Norris James Clement Mooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Kent Avenue Baltimore, Maryland 21207 Gloria Strickland - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 02/06/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign ture of Funeral S vice Licensee David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death . Enter the shock, or heart fail Immediate Cause (Final Physician/ nto tem disease or condition 480C Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 | Fetal deat 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day the P.O. | ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 20 No မ 5 Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident

Hospital or Attending Physician: Division of Vital

Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined EScertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number
1) 3 8 7 6 2 29b. Signature and title of certifier

State Registrar

Medical

31. Date filed (Month, Day, Year)

Red

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 011C

010

Sharon J. Mc Cormack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 27, 2012 11:23 PM John Lawrence Smith, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Raltimore 223 S. Collington Avenue Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** Min. (Month, Day, Year) Days Hours 218–38–3266 **Director** 1 XM 2 □ F West Virginia 11/07/1940 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral United States 21231 223 S. Collington Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: 3 Widowed 4 Divorced Completed Year or Dates.1958-62 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith Stout Cleve Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 S. Collington Avenue Paltimore, Maryland 21231 Dorothy Mae Smith - Wife 20b. Place of Disposition (Name of Horney), Higher or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 02/01/2012 Middle River, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Raltimore, 21. Signature of Funeral Service License Street Raltimore, Maryland 21231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metalbases Covernoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or injury To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ▼ Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29d. Date signed (Month, Day, Year) 29b. Signature Hen29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

11:23pm

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Smith

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 28 28 2012 Dennis Stanley Szabelski, Sr. 10:30AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/09/1946 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Count Maryland 218-44-0010 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No U5MC

If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates. (968-70 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. 2 Andrew Szabelski Laura Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health s item 27 is Marianne Hadlir / Daughter 1208 Griffith Place, Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of I Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/1/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, O BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pseudomem branous Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Acute Renal 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Atherosclerotic Cardiovasular performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🕦 No 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🛱 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 2 L Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 124 hours a Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) yan Surono 50653 1-30-2012

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Road.

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State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death D310 Physician/ Ž012 12:55 AM January Bobby Ray Stables Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Harford Upper Chesapeake Medical Center 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In vrs. last birthday) If Under 1 Year **Funeral** Days Hours (Monto PP1/1941 County aryland Min. 213-38-9465 70 1 M 2 D F **Director** Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🕇 No MD Harford Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21154-1532 1318 Heaps Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 XMarried þ ☐ Yes Yes, Give 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Test Driver Federal Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Georgia Hurt William Henry Stables 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is ranging any injury or other trees. Kathleen A. Stables / Wife 1318 Heaps Road, Street, MD 21154-1532 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/1/2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying m800534904 Exami D01243T. Cause (Disease or injury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bobby Ray 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury ➢ Natural 5 Pending 1 Yes 2 No Investigation Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Homicide within 24 hours a **Fo the Funeral C** completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 54 7 8 1 29d. Date signed (Month, Day, Year) 29b. Sign 1130 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 520 upper chesapeake Drive Bei Air MD 21014 mark Gonzemo FEB 0 2 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per Maryland / Department of Health and Mental Hygiene amend #5 Per FH G925 3/12/2012 JH
Reg. No.

Reg. No. State Registrar Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:33 AM 2012 Norman Bernard Scott Sr. Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Himor 9. Birthplace (State or Foreign Country) MD 8. Date of Birth 5. Social Security Nambers **Funeral** 6/8/1931 Min. 1**X** M 2 □ F Months Hours Days 80 215-24-3160 **Director** Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State aţ with the Maryland Director narment of Health and Mental Hygiene. nortant: If Item 27 is marked other than "natural", or items 23a or 28a-f si injury or other traumatic event, the Medical Examiner must be notified 1 X Yes 2 □ No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21205 Funeral 525 Streeper St Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Employed Self College (1-4 or 5+) Elementary/Seconday (0-12) Furniture 10 18. Mother's Name (First, Middle, Maiden Surname) U 1 1 17. Father's Name (First, Middle, Last) UA H should be file and Mental F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 2840 Mayfield Ave Baltimore MD 21213 19a. Informant's Name/Relationship (Type: P : *) . Page 1 and 2 sl ment of Health a tant: If item 27 i Miles T. Scott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hanover MD 2/2/2012 Ardent Crem Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E. Oliver ST Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Scott, Norman Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No after death.

Director: After this certificate has been signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 Tes 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital or Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY 31,2012 D0051865 ST AGNOS HUSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES CURTIS BALTIMORE 31. Date filed (Month, Day, Year) FEB 0 2 2012 32. Registrar's Sgnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral Director		5. Social Security Number 411–36–1758		M 2 □ F 7.	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Birtl $a_{\mathbf{n}}^{(Month}1_{8}^{Day}$		g. Birt Ten:	nplace (State or F intry) 1 •	oreign
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21215-0036	1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status1 ☐ Never Married 2 ☐3 ☐ Widowed 4 ☐ Di	Married	12. Was Decede Armed Force 1 Y Yes 2 If Yes, Give Year or Date	es?	l'	Was Decedent of H f Yes, specify Cuba	an, Mexicar	n, Puerto R	ican, etc.)		Race - Amer Black, White cify: Wh:	, etc.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Scott S	ima	k S 1- For State Registrar	tate of Maryla		artment o		nd Me	ental Hy		eg. No.	201	2 0270
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Medical Exam	iner	ECOLECT DOOCC							Month January 2			1841 hrs
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		nder 24Hrs.	8. Date of Bir			thplace (State or
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	edical	(Check only Certifying Pi	hysician: To the besi mlner:On the basis o									
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_	}	30. Name and address of person	who completed caus	e of death (Item	23a)							
			istant Medical E			more Street	, Baltim	ore, MD	21223			7
		31. Date filed (Month, 1997)	2 2015 ^{32. Re}	gist ar's Signatu	ire A	ho as s			-			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 201^{rea} ROBERT LEE SELBY, JR. 5:36A M January Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore County GILCHRIST HOSPICE CENTER Towson 8. Date of Birth (Month, Day, Yea, Mar 10, 1 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Maryland Hours 1 X M 2 🗆 F 47 216-90-9546 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 X No Baltimore County Parkville Maryland | 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral **USA** 21234 1212 Dalton Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces Yes 2 X No Yes, Give 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Restaurant Services Kitchen Prep Servicer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thompson ၉ Betty L. Robert Lee Selby, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Hammen Avenue, Timonium, MD 21093 (Sister) Donna Adolph 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important: If any injury or 2/2/2012 Moreland Mem Park Baltimore, Maryland 4 Donation 5 Other (Specify) MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to or as a consequence of: if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phys the attending p IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS 3 CP 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Manner of Death 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year) 29b. Signature and 00071287 30-12 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, Baltimere MD 21204

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB U 2 2012

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AN UAR) JAMES WILLIAM TURNER, SR. 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) (Month, Day, Year) Hours Min Country) 229-44-5568 **Director** 1 X M 2 🗆 F 12-18-1935 75 NY Usual Residence of Decedent · 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 X Yes 2 No MD Prince George's Riverdale ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a Examiner must be Funeral 6277 64th Avenue, Apt. 4 20737 USA Page 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black Completed 3 - Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Montgomery Co. Public Schools Custodian Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Harry Hayes Turner, Sr. (Unav.) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Turner/daughter 6277 64th Avenue, Apt. 4, Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 01-24-2012 Suitland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH, 4111 Pennsylvania Ave., Suitland, MD 20746 Enter the disease Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final KRDIKC Physician! disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Nuknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 After this certificate has 1 Tyes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: ည 1 🗌 Yes 2 X No 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifie

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WKSSOUD NEMAT) MD 3001 HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Larkin Taylor 2012 8:50 a M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairhaven Carrol1 Sykesville If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) -b 20 1922 241-30-9400 89 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 7200 Third Avenue 21784 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married within 72 hours after of þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) office management permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene
Important: If item 27 is marked other the office assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ernest W. Larkin Lucy McIver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Taylor (daughter-in-law) 2460 McKendree Rd., West Friendship, MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 2/4/2012 Oakdale Cemetery 4 Donation 5 Other (Specify) Washington, NC Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel, PA Parge Harget Herber PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysiciani disease or condition resulting in death) na sears Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 \ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an e Hospital or Attending Physician: The law rage hours after death.
9 Funeral Director: After this certificate has b cate has l autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) funeral director, Be Hospital: Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Iniury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier t 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D34849

State Registrar

9

Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-00858	
Charles Tutt	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physici	an/	Decedent's Name (First, Middle,Last)				Date of Death Month D)ay Year	3. Time of Death 0731 hrs	
∕ledical Exami	iner	Charles Tut 4a. Facility Name (if not institution, give street and number)	t	4b. City. Town, or	Location of Death	January 29,	4c. County of Death		
		St. Agnes Hospital		Baltimore NA					
Funeral Director		218-58-7553 1XM 2 F 59	n yrs. last birtl	hday) If Under 1 Yea Months Day Yrs.		-	MM/DD/YYYY) 9. Bir Foreig Co		
AOY		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town	or Location				10d. Inside City Limits	
	ក	MD NA	Balti	lmore				1 Yes 2 No	
ith the Maryland 23a or 28a-f sho eotified at ooce.	Director	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	ntry?	
ith the		601 N. Denison Street 11. Marital Status 12. Was Decedent Eve	er in IIS	212 13. Was Decedent of His		ecify Yes or No-	USA 14 Race - Ameri	ican Indian, Black,	
leath w r items	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2		If Yes, specify Cuba	n, Mexican, Puerto		White, etc.	African	
after c	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:		1 Yes 2 No			Specify: A m ∈		
2 hours "natur		15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)	(ed) 16a. E	Decedent's Usual Occupa during most of working life			6b. Kind of Business/	Industry	
036 ithin 7, ne. r than	Completed	12th Grade NA		Laborer			Home Imp	rovement	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho injury or other traumatic event, the Medical Examiner must be softsted at osce.		17. Father's Name (First, Middle, Last)				(First, Middle, Mai			
212' uld be Mental marke	To Be	Benjamin Tut 19a. Informant's Name/Relationship (Type, Print)	. t 19t	o. Mailing Address (Stree	Harri et and Number or F				
MD id 2 sho lith and m 27 is		Betty Webb-Sister		4009 Primr	ose Ave	nue Bal	timore,M	ID 21229	
ore, es l and of Heal friter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place o	of Disposition (Name of ce ory or other place) ZION CeM •		Date 2 - 0.3 - 1.2	20c. Location - City or Lansdow		
Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service/Licensee	mt.						
Bal permi Depar Impo injur	8 63	21. Signature of Figure 3 Service Licensee		22. Name and Addres				e, MD 21217	
Physician	-	23a. Part I. Enter the disease, o complications that caused the failure. List only one cause on each line.	death. Do no	ot enter the mode of dying	, such as cardiac o	r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and	
Medical Examiner		Immediate Cause (Final disease a. Hypertensiv		rosclerotic	Cardiova	scular D	isease	Death	
		or condition resulting in death) Due to (or as a conseque b.	rice or).						
	iner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause	ence of):						
JV - :	Examiner	(Disease or injury that initiated events resulting in death) Last	ence of):						
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60, ate be e hysicia e buria	Wedical	IF FEMALE: 23c. If yes, outcome o					23d. Date of delivery	,	
Sox 6876 death certificat te attending ph		23b. Was decedent pregnant in the past 12 months?	2		Ectopic pregna	ncy	Month E	Day Year	
Box e death the atter ed for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	eordeath 5	Other (Specify)					
s, P.O. uires that the signed by t	-	Part II. Other significant conditions contributing to death but				23e. Did toba	acco use contribute to	the cause of death?	
ords, P	Completed by	Narcotic use, Hepatitis C,	Human	Immunodefic	iency	24a. Was an		itopsy findings available	
Recore The law re ficate has be	mple	Virus (HIV)				autopsy performe	ed? death?	completion of cause of	
tal Recises: The certificate ector, page		25. Was case referred to medical		26. Place	e of Death (Check	1 Yes 2	No 1 Ye	es 2 No	
Vital hysicino:	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient	2 ER/O	utpatient 3 DOA	Other Nursin	g Home 5 Re	esidence 6 Other	r:	
n of dieg Ph	L:uo	27. Manner of Death 1 X Natural 5 Pending	28b. 1		ıry at Work? Yes 2 No	28d. Describe hov	w injury occurred		
ision Atteorated the control of the	Certification:	2 Accident Investigation 28e, Place of Injury	- At home, fa	arm, street, factory, office I		28f. Location (Stre	eet and Number or Ru	ral Route Number, City	
Div pital or urs after rral Div	ertif	3 Suicide 6 Could not be determined (Specify)			0	or Town, State	re)		
8 - 5 > 1 29a Certifier 7 a life 7 th									
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated. 29b. Signature and title of certifier	orr arra/or II	29c. Licens			29d. Date signed (Mo.		
		WIP. Roullitte	5)	O.C.			January 30, 2012		
- Ø		30. Name and address of person who completed cause of death							
(~		Melissa Brassell, MD Assistant Medical Ex			Street, Baltimo	re, MD 21223			
S Reais	tate trar	31. Date filed (Month Day Year) 32. Registrar S	Marian	Car					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2012 Year Physician/ 3:15 Рм 31 Lusetta B. Thompson January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Havre de Grace 3900 Rock Run Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 219-42-0303 1 □ M 2 🗶 F 72 **Director** 9/9/1939 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛚 No Maryland Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral USA 3900 Rock Run Road 21078 death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 Never Married 2 Married Yes Specify White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Letter Carrier Postal 12 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Belsterling Russell Garber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B846 Rock Run Rd, Havre de Grace, MD 21078 Deborah Markline / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Mem. Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/3/2012 Aberdeen 4 Donation 5 Other (Specify) 72. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Tarring-Cargo Funeral Home, MD 21001 333 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onsel and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequ-o e of) **Examiner** quarticity list end of three if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 | Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No 5 Pending injury 1 Matural Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier

State Registrar 30. Name and agoress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Tedrow Wayne Burdette 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) County of Death | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | June | 24 | 9. Birthplace (State or Foreign Age (In yrs. last birthday) Year 920 1 🕱 M 2 🗆 F Pennsylvania 91 233-09-2214 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No Aberdeen Maryland Harford 10g. Citizen of What Country? 10e, Street and Number USA 21001 <u>715 Shirlev Drive</u> Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. 2 □ Nal 944-1 Never Married 2 Married 1 ☐ Yes XX No Specify. Specify:White 3 ₩Widowed 4 □ Divorced 1967 Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Army Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ancill L. Eva Tedrow В. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Mt. Royal Ave., Aberdeen, MD 21001 Marvin_Tedrow 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 1/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gard: Aberdeen, MD 21. Signature of Funeral Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21001 MD Aberdeen. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between 23a, Part 1. Enter the disease Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to lot as a con equence of Provintially list so witto is if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or resulting in death) Last as a consequence of ves, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death

Physician/ Medical Examiner

permit. Page 1 s
Department of H
Important: If ite
any injury or ot

Physician/

Medical

10a. State

Director

Funeral

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Completed

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Examiner

Funeral

Director

mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nardment of Health and Mental Hygiene.

oortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

by Physician/Medical Be Completed

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Certificate:

Medical

s been signed by the attending physician and should be detached for use as the burial-transit After this certificate has

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

Records, P.O.

Vital

Division of

death.

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown

5 Pending

Investigation Could not be

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No

31. Date filed (Month, Day, Year

FEBUZZII

27. Manner of Death

Natural
Accident
Suicide

1 Yes 2 No 3 Probably 4 Unknown 24a, Was an

Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

prior to completion of cause of death?

performed 26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number,

30

12

23e. Did tobacco use contribute to the cause of death?

246. Were autopsy findings available 2 9 No 1 Yes

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as sta	
(Check	2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the c	caus

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

se(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed [Month, Day, Year)

Other:

work? 1 ☐ Yes 2 ☐ No

28c. Injury at

ss of person who completed cause of death (Item 23a) (Type, Print

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

21078 MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D28 2012 Physician/ Syndia Winder 3:05 P M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs, last birthday) **Funeral** Hours Min Director 1 M 2 F MARVIAND 28a-f show Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? 1021 N. MONROE 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NONE Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Collins WINDER 19a. Informant's Name/Felationship (Type, Print) DAC 4 h 🖰 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 1444 AIS Duith St. UNDIA WASHINGTON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MARY IAND METRO CREMATORI 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Andress of FATTA E DERRICK C, JONES, FIH, P, A ature of Funeral Service Licensee ts. AUE. BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 1 Phylician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown signed by the Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: <u>_</u> 2 **M**o 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 MIX h-KNOX State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last, 3. Time of Death Month "23 2012 Physician anuar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give Examiner Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours **Funeral** Months 1 M 2 X F Sept 8, 1960 Maryland 214-84-6776 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 📉 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21224 6309 Brown Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify. 2 3 X Widowed 4 □ Divorced (Give kind of work done during most of working life. DO NOT use retired) Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6309 Brown Ave; Baltimore, MD 21224 James Waybright - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in 22. Name and Address of Facility State Anatomy Board 21. Signature Funeral Service 21201 655 W. Baltimore St; Baltimore, MD m Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last physician Box 68760, Physician/Medical the use as attending 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) igned by the at the detached for 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗌 No 1 Tes certificate 26. Place of Death (Check only one) Attending Physician: 25. Was case referred to medical director Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 21/2 No 2 ER/Outpatient 3 DOA Inpatient မ 24 hours after death. Funeral Director: After this completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: (Month, Day Injury Natural 2 Cident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only To the I within 2. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) FEB 0 2 2012

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RABILE 3. Registrar's Signature Land

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospice Care If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 12-24-57 216-78-5825 Director 1 □ M 2**X** F 54 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director X☐ Yes 2 ☐ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 5005 Frederick Avenue USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. African 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: American Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) NA Never work 7th Grade Nrver worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ၉ Wright Leroy Holiday Arita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 Frederick Avenue Baltimore, MD 21229 Iisha Wilson-Niece item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. ☐ Burial 2 【X Cremation 3 ☐ Removal from State 02-02-12 Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a: Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition neumonia Physician/ Medical resulting in death) ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ō in the past 12 months? Month Dav Year sate has been signed by the a page 2 should be detached Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other 2 **N**o မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Physician/ IN RIGHT ul Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** BALTIMORE 10090 MILL RUN_CIRCLE APT302 OWINGS MILLS If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 218-22-3590 1 □ M 2 □ F Director 8-5-1925 SOUTH CAROLINA 86 28a-f shov 10d. Inside City Limits 10a. State 10c. City. Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No BALTIMORE OWINGS MILLS MD. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10090 MILL RUN CIRCLE APT 302 21117 death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: BLACK "natural" 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) SPRING GROVE HOSPITAL HOUSEKEEPING of Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ JAMES HOUSE LOUISE NELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10090 MILL RUN CIRCLE APT 302 OWINGS MILLS, MARYLAN OPHELIA WRIGHT (DAUGHTER) nt of Hea t: If item or other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 C mation 3 \square Removal from State Department of Important: If any injury or Other (Specify) 4 Donation 5 MARYLAND NATIONAL 2-3-2012 LAUREL, MARYLAND D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Service Licencee JONATHAN MONROE ST. BALTIMORE, MARYLAND 21217 1721-27 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physicing disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown the 9 Unknown director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinating and/or investigation is provided by the control of the cause of examinating and/or investigation is provided by the control of the cause of examinating and/or investigation is provided by the cause of the Medical 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Pringle)

State Registrar

DHMH 17 Rev 06-2011

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 28 , 2012^{ea} 0900 Robert Stanley Walker. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days XX M 2 D F Months Hours 77 Yrs. Director 215-32-7393 934 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1xXYes 2 No Maryland Harford Aberdeen 10e, Street and Number ō 10f. Zin Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a may injury or other traumatic event, the Medical Examiner must be a Funeral 895 Walker Street 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Warehouse Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stanley Walker, Sr. Robert Phyllis Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Walker (wife) 895 Walker Street, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 1/31/2012 Ferris & Comp. West Chester, PA 21. Signature of Funeral Service Ligense Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (NOVSTIVE physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 the Hospital or Attending Physician; 25. Was case referred to edical examiner? 26. Place of Death (Check only one) of Vital Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending - Natural injury Division 2 Accident Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 8, 201

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{rea} 1:34pm M Judith Ann Allaire January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
July 2, 1949 9. Birthplace (State or Foreign Country) Massachusetts If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F 62 **Director** 017-40-2202 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Mount Airy 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 4395 Adam Court United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ Yes 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 N Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Industrial Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Thibeault Ruth Ela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Heritage Farm Drive, Mount Airy, MD 21771 Jonathan Allaire 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/16/2012 Alexandria, Virginia 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner espilatory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Lue to (as a conseque ce of): Exami requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠∠ 9 ☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has le 2 autopsy this certificate 1 Yes 2 No Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 100 ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Natural within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu М 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title

31. Date filed (Month, Day, Year)

JAN 17 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

186

Rohatgi, M.D., 8600 Old Georgetown Road, Bethesda, MD 20814

1)006 1302

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Christina Akoto **AKA** Christiana Akoto 2012 1:45 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01ney Montgomery Montgomery General Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** June 16,1940 Hours Min **Director** 578-06-1598 1 □ M 2 🏅 F 71 Ghana ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 212 L. Marsh Hollow Place United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Armed Forces Black White etc 1 Never Married 2 X Married Yes 2 X No ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. B1ack 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wiu. Hal Hygiene. Har than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home marked other Be Department of Health and Mental Hy, Important: If item 27 is marked Any any injury or other **** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adwoa Dede Duah Kwaka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Akoto (Spouse) 212 L. Marsh Hollow Place, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State January Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD <u> 2012</u> 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Fureral Service License RACIO MOIII 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Gequentially 1st conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed that initiated events resulting in death) Last the attending physician Physician/Medical use as the bu P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) ned by the a e detached i a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? _1 □ Yes _2 □ No 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Sompletely** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 01 Prince Philip 01ney, MD 20832 18101 Prince Drive, 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Jan 5:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Genesis HealthCare -The Pines Easton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Hours Min 40-9112 **Director** Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No ton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 601 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 72 hours after permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan once. 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) · Vat Ta Ker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Junet 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROYAL OAK (EMETER) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses uneral Home, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner MORKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No cate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital ၀ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 16 8:00 Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tospice at the bur omico Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 | F Months Hours **Director** -/6 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 5/ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) r than " , the Mr Elementary/Seconday (0-12) College (1-4 or 5+) gricultu other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname is marked ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra homa Box 17 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician HALDNIC. TRUCTIUR 14 LACON AME disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician a completed filled in by the funeral director, page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months? Month 2 No 1 L Yes 2. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) examiner? 1 🗌 Yes ည ph 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Tes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) d title of certifier 29b. Signature at 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year)

State

Registrar

arka

Registrar's Signatur

IAN 18 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lawrence Gilbert Bohlen lanuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital at Easton Easton Talbot If Under 24 Hrs. Hours Min. 5. Social Security Number Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months 214-30-5497 78 **Director** 1 **X** M 2 □ F Nov. 7, 1933 Maryland Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director MD Dorchester Cambridge 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1226A Hudson Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 1953-83 Year or Dates: 1 ☐ Yes 2 X No Specify. white 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bohlen, Lawrenc I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) lawyer law practice and Mental Hygie is marked other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John E. Bohlen Marie Scharmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy I. Bohlen wife 1226A Hudson Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Dorchester Mem. Park 1/20/12 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P 700 Locust St., Cambridge, MD 2161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events Directo for he minorinadularina of ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year Day Pregnant at time of death g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 No Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funera 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie 29b. Signature 4965656 son who completed cause of death (Item 23a) (Type, Print) MO 2/601 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02725 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O I Vear 04:25AM BURTON Physician/ 2012 MARJORI E Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Woods Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) 1 □ M 2 💢 F Yrs. Director 218-20-6239 Usual Residence of Decedent 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21413 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married Yes 2 No þ Specify: White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygleine. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Jale. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Martha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Canne 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -ambridge ster Menerial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1ewconb 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA. Immediate Cause (Final STAGE END Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner sician and burial-transit attending physician I for use as the buria been signed by the should be detached

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Togi Fydilling	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): d	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔑 Unknown
ombiere			24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
2	25. Was case referred to medical	26. Place of Death (Check on	nly one)
0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Noursing Home	5 Residence 6 Other (Specify)
care:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No	Describe how injury occurred
Certil	3 Suicide 6 Could not be 4 Homicide determined		. Location (Street and Number or Rural Route Number, City or Town, State)
nedical	Check 2 Medical Evan	sician: To the best of my knowledge, death occured at the time, date and place, and d iner. On the basis of examination and/or investigation, in my opinion, death occurred at the se Practioner: To the best of my knowledge, death occurred at the time, date and place, a	e time, date and place, and due to the cause(s) and mainer stated.

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CAMBRIDGE

29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BYRN

32. Prigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RODGER STEPHEN BRADY 0332 M 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICS SALISBUN TENISSULA 9. Birthplace (State or Foreign Year If Under 24 Hr 8. Date of Birth **Funeral** 11-26-1944 MARYLAND 216-48-2293 **Director** 1 **X** M 2 □ F 67 Yrs. 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No DELAWARE SUSSEX OCEAN VIEW 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a 14 MITCHELL AVENUE 19970 U.S. or items "natural", or item edical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmin. Elementary/Secondary (0-12) AUTO PARTS MANUFACTURING PRODUCTION PLANNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN F. BRADY MILDRED COOKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY A. BRADY/SPOUSE 14 MITCHELL AVE, OCEAN VIEW, DE. 19970 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗀 Burial 2 🗓 Cremation 3 🗆 Removal from State MELSON'S CREMATORY 1-18-2012 FRANKFORD, DELAWARE 4 Donation 5 Other (Specify) MELSON FUNERAL SERVICES, LTD. 38040 MUDDY NECK RD, OCEAN VIEW, 19970 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. shock Immediate Cause (Final Onset and Death DISEASE Physician/ DRONARY disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or ithat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Пау Month Year Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending 2 Accident Investigation
6 Could not be Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🚜 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one

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Registrar

npleted cause of death (Item 23a) (Type, Print) 1.D. /00 /= /01

Pegistrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13^{Day} 201^{Yea} 3:13 P M Robert Craig Bowers January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College View Center Frederick Frederick 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday) Funeral Year 957 Hours Min March 4, 1 🕱 M 2 □ F 212-68-9633 Mary Tand Director 54 Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Frederick Frederick 1 X Yes 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 13 W. 7th Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene.
sart: If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building Trades 12 Lighting Estimator Be 18. Mother's Name (First, Middle, Maiden Surname)
Grace C. Engle 17. Father's Name (First, Middle, Last) ဂ္ Melvin R. Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 W. Main St. Thurmont, MD 21788 Department of Health Important: If item 27 any injury or other tr Jackie Bowman / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Jan. Resthaven Crematory 2012 Frederick, Maryland 4 Donation 5 Sthe (Specify) 21. Signature Fundal Septice Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ VY 4051) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar

DHMH 17 Rev 7/2009

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MD

31. Date filed (Month, Day, Year)

JAN 18

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32. Registrar's Signature

5251A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Isabel Frances Butler 2012 January 10:50 p ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 15231 Red Clover Drive Rockville Montgomery 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Count NY **Funeral** Days 1 M 2 X F Hours 579-52-6234 93 July 21, Year 918 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County by Funeral Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Rockville 1 🗌 Yes 2 🛚 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15231 Red Clover Drive 20853 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Midowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Senate Staffer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ William Dowling Mary Kenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Kenneth W. Butler/Son 19113 N. Pike Creek Place, Montgomery Village, MD Date 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arlington National Cemetery 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Feb. 4 ☐ Donation 5 ☐ Other (Specify) 2012 Arlington, VA 21. Signature of Funeral Service Licensee

Francis

500 University Blvd. W., Si

23a. Part 1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Terminal Cardiac Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-tag that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia prognolical, allied in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 3 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of pertif 29d. Date signed (Month, Day, Year) M January 16, 2012

State Registrar

DHMH 17 Rev 7/2009

arted

9901 Medical Center Dr., Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy L. Schiffman, MD

31. Date filed (Month, Day, Year) **JAN 17** 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AVEND#20loperFH, 1/20/12; PMW, McCo Certificate of Death 2. Date of Death Physician/ 13. 2012 John Charles Beckett January 4:21 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death Casey House-Montgomery Hospice Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day Yes Davs Hours Min Year) 1952 Months 042-46-0241 **Director** 59 Connecticut 1 **X** M 2 □ F Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland 28a-f Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 705 Chestertown Street 20878 United States items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Force Black, White, etc. ò þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates.Vietnam "natural", Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Department of (Give kind of work done during most of working I Hygiene. Gife. DO NOT use retired)
Survivor Care Program
Manager Elementary/Secondary (0-12) College (1-4 or 5+) Defense n and Mental Hygier 7 is marked other t 5+ other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ William John Beckett Florence Normandin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 is any injury or Attack (Spouse) Valerie Beckett 705 Chestertown Street, Gaithersburg, MD 20878 20a. Method of Disposition Unk Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Cemeterv 1-20-2012 22. Name and Address of Facility DeVol Funeral Home, M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 Part I. Invertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. bart : Immediate Cause (Final Onset and Death Physician/ a Nonsquamous Cell Lung Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to initial educate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ding IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death ISe 23b. Was decedent pregnant 23d. Date of delivery for u Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death
Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? certificate 2 No 1 Yes ☐ Yes 2 X N Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🔀 No 1 Tes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 St Other (Specify) Hospice မှ hours after death.

Ineral Director; After this (1) filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending work' Accident
Suicide 1 🗌 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

within 24 hours a

Registrar DHMH 17 Rev 06-2011

State

Wedical

29a. Certifier (Check

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

Geoffrey Coleman, M.D.,

7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D37142

1355 Piccard Drive, Suite 100, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

January 16, 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Marvin Shellman Childs, Sr. O'Inth Medical 98 2012 2:40 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Numbe **Funeral** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Rirth Birthplace (State or Foreign Country) Director 220-20-2745
Usual Residence of Deced (Month, Day, Year) 1**X** M 2 □ F 86 06/09/1925 MD 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Carroll Westminster 1 XYes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 925 Ruby Court 21158 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other them 4... USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, à 1 Never Married 2 Married Black, White, etc. Completed 3 Widowed 4 Divorced 1 Yes 2X No Year or Dates Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Letter Carrier **USPS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Childs Grace Belle Armacost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Childs/wife 925 Ruby Court, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Poplar Grove Cemet. 01/12/2012 Cockeysville, MD Signature of Funeral Se 22. Name and Address of Facilit Pritts Funeral Home and Chapel ally 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Onset and Death Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical certificate be Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death ò in the past 12 months?

1 Yes 2 No 3 Ectopic pregna 5 Other (specify) 23d. Date of delivery Ectopic pregnancy Pregnant at time of death 1 Yes 2 L 9 Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown has . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Division of Vital Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manper of Death 28c. Injury at work? Natural Date of injury (Month, Day, Year) 28b. Time of s after dea. 28d. Describe how injury occurred 5 Pending Accident Investigation
6 Could not be 1 Yes 2 No Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29d. Date signed (Mohth, Day, Year) WIL

State Registrar 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 12, 2012 4:50pm^M Patricia L. Finegan Clubbs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours (Month, Day, Year) an. 1, 1945 1 🗆 M 2 🔀 F Washington, DC Director 215-46-3660 67 Jan. Usual Residence of Decedent show or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Maryland | Montgomery Bethesda 5 10e. Street and Number 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Completed by Funeral 9911 Holmhurst Road 20817 United States ral", or items: Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 X Married 1 Yes 2X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event; the Medical. once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Vincent Finegan Gladys Irene Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9911 Holmhurst Road, Bethesda, MD 20817 James D. Clubbs (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 1/16/12 Silver Spring, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee TRACY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on. Tand Transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Year Dav To the Hospital or Attending Physician: The raw required within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a series of the funeral director page 2 should be detached from 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ည 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pragitioner: To the Less of my knowledge, shall unduring all the fine, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

14:50

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Potric

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTON M. PRIEGO 31. Date filed (Month, Day, Year)

JAN 17

D233cB

6420 ROCKLEGGE DR BETHESOAMD QUETT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01/07/2012 VICIOR CLEMENCEAU 0915 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgamery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours Min. (Month, Day, Year) **Director** 015-34-4182 91 1X M 2 D F 02/11/1920 Romania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14421 Traville Gardens Circle, #212 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 XMarried 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Mechanical Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ion Cecalaceanu Maria Bucur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14421 Traville Gardens Circle, #212, Rockville, MD Henriette Clemenceau/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Svc 01/10/2012 | Hanover, MD 21. Signatur of Funeral Se 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Days Aspiration disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ath ceres ementia the Hospital or Attending Physician: The law requires that the death certificate be executed 4ears Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23h. Was decedent pregnant 23d Date of delivery in the past 12 months? 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performe within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 2 🗌 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 No 1 Yes 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D 31391 cause of death (Item 23a) (Type, Print) 30. Name and address of pers 6045, Frederich Ave 1faraq MD 2413 Gaithersburg MD 20877 31. Date filed (Month, Day, Year) State **JAN 17** Registrar

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1 - For State Registrar

Medical

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items 23a

must be notified at

Director

Funeral

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Completed

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State Registrar			Oldio C	71 1110	y iai i		,		e of L				incar i	, ,	. No. 7	20	12	Π	273
I. Decedent's Nam	e (First, Middle,	Last)										2.	Date of	Death	Day		Year	3. <u>Ti</u>	me of Death
RICHARD :	LECANRD	CAF	RTER										IVIOTILI	1/	Day 3/2	012		5	:30 a _M
a. Facility Name (if	not institution,	give stre	eet a <i>nd nu</i> n	nber)			4	4b. City,	Town, or	Locatio	n of Deat	h			4c. Co	ounty o	f Death		
Shady Gr Social Security N		pita 6. Sex	1	7 4-0	7	and blutte		Rock If Under	vill.		er 24 Hrs	Lo	Dete of	Diath	Mon	-21	mer		tota on Familia
			M 2 🗆 F	7. Age (in yrs. i	ast birtho	, I	Vionths	Days	Hours			Date of (Month,	Day, Ye	ar)			nplace (S n <i>try)</i>	tate or Foreign
236-52-8 Usual Residence		142	IVI Z LL F		7	'2 Yi	rs.					8,	/5/19	939			Pen	nsyl	vania
0a. State	10b. County			1	10c. Cit	y, Town o	or Locat	tion											ide City Limits
MD	Montgo	mery	7	I.	íont	game	ery	Vil:	lage									ıχ	JYes 2 ☐ No
De. Street and Nur	nber							10f. Zip	Code					100	. Citize	n of Wi	hat Cou	intry?	
9322 Dunl	oridge I	Way						2088	36					lus	A				
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1 Never Marr		ied	1 Yes If Yes, Giv Year or Da	/e	o P	ımy	1 [Yes	2 X No	Speci	fy:				Sp	ecify:	Bla		
	15. Deceden		ation			16a. D	eceder	nt's Usua	al Occup	ation				16	b. Kind	of Bus		ndustry	
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7. Father's Name (ther's Na rind		irst, Midd Paqe	lle, Mai	den Sur	mame)			
9a. Informant's Na	ame/Relationsh	ip <i>(Typ</i> e,	Print)			19b. l	Mailing	Address	(Street	and Num	ber or Ru	ıral Ro	oute Num	ber, Ci	y or To	wn, Sta	ate, Zip	Code)	
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	☐ Cremation 5 ☐ Other (S)		moval from	State		enwa	_	-			1/2	0/3	2012	Wh	nee 1	ina	r. W	7.7	
1. Signature of Fu	neral Service Li	censee	MO1:	57	43		22.1	Vame an	d Addres	ss of Fac	ility Sn o)Wa	en F	une	ral	Har	ne,	P.A	20850
23a. Part 1. Enter t					he deat	h. Do not	t enter t	the mod	e of dyin	g, such a	as cardia	or re	spiratory	arrest,			Ť		ximate
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Cause (Disease or hat initiated event	injury	c.																	
esulting in death)	Last		Due to	(or as a	consequ	uence of)	:												
	,	d.															\rightarrow		
FEMALE:		Т													Т				
3b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	230	c. If yes, out 1 Live 4 Preg 9 Unk	nant at t	pregna Feta ime of c	ncy al death death	3 E 5 C	Ectopic ; Other (sp	oregnand ecify)	у				_	236	d. Date Mont	of deli	very Day	Year
art II. Other signi		ns contr	ibuting to d	leath but	not res	ulting in	the und	derlying	cause giv	en in Pa	rt I.		23e. Di	d tobac	co use	contrib	oute to	the caus	e of death?
CHRONIC	KIDA	JEY	DISC	EASE									1	☐ Yes	2 🗶	No 3	3 🗌 Pro	obably	4 🗌 Unknown
CORONAR	Y ARTI	ERY	DISEA	ASE									pe	itopsy erforme	d?	pr de	ior to c eath?	ompletio	lings available n of cause of
5. Was case referr	ed to medical			-					26 PI	ace of D	eath (Che	ck on	1 \(\text{Ye} \)	es 2	No	1	⊔ Yes	2 X N	lo
examiner?	X No	Hos	spital:	Innetice	t 2 🗆	ER/Outp	nationt	3 🗆 Г	Othe	er				noiden -	0.6	Other	(Cnool	5.1	
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2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determi	not be	28e. Place buildi	of Injury	- At ho	me, farm	n, street			160 2	L NO	28f	Location			lumber	or Rura	d Route	Number,

Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 2 should be detached for use as the burnariest completely filled in by the funeral director, page 3 should be detached for use and funeral director for the funeral dir Physician/Medical Division of Vital Records, P.O. Box 68760 Medical Certificate: To Be Completed by

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CORONARY ARTER	Y DISEASE	24a. Was an autopsy performed? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 🛣 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	26. Place of Death (Check on	ly one)
examiner? 1 Yes 2 No	Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No	. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 4

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0064502

29d. Date signed (Month, Day, Year)

13

MARYLAND

2012

20850

JANUARY

ROCKVILLE

29c. License number

31. Date filed (Month, State

(Check only one) 29b. Signature and title of certifier

son who completed cause of death (Item 23a) (Type, Print) d address of pe CARPENTER BRIAN MD Day, Year)

CENTER DRIVE 9901 MEDICAL 32 Registrar's Signat

Dodds, Barbara 1/3/12 5.04 pm

			For State	State of Maryla		artment of F tificate of E			21	012	02734
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	lilicate of L	Jean I	2. Date of Dea	ith		3. Time of Death
	Physicia Medic		Barbara Brasefiel					January	_		5:04 P M
	Examin	er	4a. Facility Name (if not institution, give str Suburban Hospital	eet and number)		4b. City, Town, or Bethesd	Location of Death			ty of Death	
	Funeral		5. Social Security Number 6. Sex 139-24-4062	_	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h , Year)	9. Birthp Count	lace (State or Foreign
	Director 3		Usual Residence of Decedent	M 2X F 79	Yrs.			May 6,	1932	Conn	ecticut
	Iryland 1-f sho ied at	Director	10a. State 10b. County DC		City, Town or Loc Shingto					11	0d. Inside City Limits 1 Yes 2 □ No
	the Ma or 28a e notif	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
	h with ns 23a nust b	Funeral	4201 Cathedral Ave			20016			United	State	es
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates.	1	Vas Decedent of Hi fYes, specify Cuba ☐ Yes 2 XNo	n, Mexican, Puerto		Bla	ace - America ack, White, e fy: Whi	etc.
1215-	ithin 72 ho ene. than "nal he Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4 or 5+)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired) maker		king	16b. Kind of Own H		lustry
Baltimore, Maryland 21215-0036	d be filed w Aental Hygia rked other itic event, t	To Be (17. Father's Name (First, Middle, Last) Charles Brasefield	1				ne (First, Middle, I Wharton	Maiden Sumar	me)	
, Mary	nd 2 should salth and N n 27 is ma		19a. Informant's Name/Relationship (Type Chauncey Dodds / I	, Print) lusband		g Address (Street a					
imore	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Vational	natory or other plac Cremato:	ry D1/12		20c. Location	Church	,VA
Balt	permit Depart Import any inj		21. Signature Funeral Service Licenses	lenan	5	Name and Addres	onsin Ave	. NW Wa	shingto	Sons I	nc. 20016
			23a. Part 1. Enter the disease for complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the decause onleach line.	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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	icate be executed physician and is the burial transit		that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):						
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Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending in the funeral Director. After this certificate has been signed by the attending in a paragletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	c. If yes, outcome of pred 1 Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnanc Other (specify)	у			Date of delive	ery Day Year
s, P.O	ires that the signed by	by	Part II. Other significant conditions cont Pulmonary Fibros		resulting in the u	nderlying cause giv	/en in Part I.				e cause of death?
Division of Vital Records, P.O.	2 2	Completed						24a. Was a autop perfor		were autop prior to cor death? 1 \(\sum \) Yes	psy findings available appletion of cause of
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on	ending eath. or: Afte the fun	Certificate:	1 Natural 5 □ Pending Dending Investigation Suicide 6 □ Could not be	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 \(\sum \text{No} \)				
Sivis	al or Att		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Town		ber or Rural	Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 L Medical Examine	ian: To the best of my knor: On the basis of examina Practitioner: To the best of	tion and/or invest	igation, in my opinic	on, death occurred a	at the time, date ar	nd place, and d	lue to the cau	ise(s) and manner stated.
	F S S S S S S S S S S S S S S S S S S S		29b. Signature and title of pertifier	W		29c. License	-		29d. Date sign	ed (Month, E 4/20	
			30. Name and address of person who con Jose Merino-Juarez		em 23a) (Type, F ld Georg	rint) getown Ro	ad Bethe	sda, MD	20814		
	Stat Registra		31. Date filed (Month, Day, Year) JAN 17 2012	62. Registrar's Sig	pature for						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#5perTNF, 1/24/12; BMW, McCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 12, 2012 2:40 A M Edwin Victor Dutra, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hsopital Rockville Montgomery 02 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Hours **Director** 1 ¥M 2 □ F 64 Jan. 13, 1947 Massachusetts show 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Montgomery Gaithersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Bayswater Court 20878 United States JANCARY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces?
1 X Yes 2 Black, White, etc. 'natural", or i ģ 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. Vietnam Completed 27 is marked other than "natur traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 18b. Kind of Business/Industry
U.S. Food and Drug (Specify only highest grade completed) Director, Regulations Policy and Management Staff Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Administration Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) DUTRA and Mental Josephine Elizabeth DeBerio Edwin Victor Dutra, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health mportant: If item 27 Paula Frances Dutra (Spouse) 5 Bayswater Court, Gaithersburg, MD 20878 injury or other Baltimore, EDWIN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan January 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Alexandria, Virginia Crematory 21. Signature of Funeyal Service License DeVol Funeral Home, 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 M01116 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition ARRHYTHMIA Medical resulting in death) Due to (or as a consequence of) Examiner RESPIRATORY FAILURE MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter oncerlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last ASPIRATION that the death certificate be executed PNEWMONIA MINUTES Due to (or as a consequence of) physician Physician/Medical BREAST CANCER MONTHS Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed CLOSTRIDIUM DIFFICILE COLITIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? X Yes 1 Yes 2 XNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 XNo ျု 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death. leral Director: Af filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the |
comple 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 12+1 MO D2069451 JANUARY 12. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD NGUYEN 9901 MEDICAL CENTER DRIVE ROCKVILLE MARYLAND 20850 31. Date filed (Mo 2. Registrar's Sign State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:55 pm Robert B. Davis 2012 January Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Brighton Gardens of Tuckerman Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-30-9573 **Director** 1 X M 2 🗆 F 82 01/29/1929 Maryland Usual Residence of Decedent show 10a. State 10b. County with the Maryland at Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f sh notified a Montgomery Silver Spring 1 Yes 2 X No Maryland 10e. Street and Number r items 23a or iner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 u.s.A. 1709 Noyes Lane should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No 1951-Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White 1953 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) B & O Railroad Train Master Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bryan B. Davis Helen Bilsborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9230 Whitney St., Silver Spring, Maryland 20901 Betsy Lee Davis - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 01/20/2012 | Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. M1564 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 1 Yes 2 9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 🗓 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 🗌 Yes 2 **X** No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

10

Registrar DHMH 17 Rev 06-2011

29b. Signature and title of certifier

Alpana Goswami

JAN 17

umna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D27660

11125 Rockville Pike, #110, Rockville, Maryland 20852

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans

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is certific director,		25. Was case referre examiner? 1 Yes 2	ed to medical No	Hospital:	oatient 2 🗆	ER/Outpatien		6. Place of Dea Other:		only one)	dence 6 \Box	Other (Specif	y)	
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10		30. Name and addre	ess of person who	o completed cause of	of death (Item	23a) (Tyne P		653	05			ry 16,		_
State		Dr. Nabi	ila Khan	1500 For	est G1	len Roa	d, Silv	ver Spr	ing,	MD 209	10			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12^{Day} Eide Jan. 201^{Year} Maureen 8:15 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Village 9703 Shadow Oak Drive Montgomery 8. Date of Birth
(Month, Day, Year)
Feb. 6. 1 Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. Director 060-42-7609 64 1947 New York Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar and once. 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Montgomery Village 10e. Street and Number 10g. Citizen of What Country? Funeral 9703 Shadow Oak Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify. 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Eide Louise Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Sickles/Sister 36 Alder Court, Kingston, New York 12401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Duriat 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/16/2012 Wiltwyck Cemetery Kingston, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home much 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Heart Disease disease or condition a Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown Day Year 1 Yes 2 D detached the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate. Completed filled in by the funeral director, page this certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Box 68760

P.O.

Records,

of Vital

Division

completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Rind, MD

JAN 17

Bruce 31. Date filed (Month, Day, Year, MD17137

5225 Wisconsin Ave. #401 Washington, D.C. 20015

January 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01:04 01 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PG Upper Marlboro 10417 Falling Leaf Ct. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral Director** 206-20-9508 86 1 M 2 V F 07/08/1925 Lynchburg, VA ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PG Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA 10417 Falling Leaf Ct. items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. or Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced "natural" Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry House Keeper Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Robert Robinson Elsie Robinson and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Jackson/Daughter 10417 Falling Leaf Ct. Upper Marlboro, MD 20774 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/21/2012 Lynchburg, VA Baptist Cemetery 21. Signature of Funeral Scott License 22. Name and Address of Facility Tyrone J. Young Funeral Services 5635 Eads Street NE, Washington DC 20018 23a. Part 1. Enter the dis shock to heart failu Immediate Cause (Final o not enter the mode of dying, such as cardiac or respiratory arrest, er the disease, or copioli aused the deat, cations heart failure. List only/o Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** our 3 yes Sequentially list conditions, many, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: □ Accider
 □ Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 14774 1-17-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIGHNAY. SHAHID AZIZ ANNAPOLIS Md 21401 DEFENSE M.D Date filed (Month, Day, Year 32. Regist JAN 2 0 2012 Registrar

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Amend		For State Registrar	19A&			-		tificate of L			Reg. No. 2	012	02741
Physiciar	1/	1. Decedent's Nam	,	, Last)						2. Date of De Month	Day	Year	3. Time of Death
Medica Examine	al .	Jacob 1 4a. Facility Name (if		give street	and number)			4b. City, Town, or	Location of Dea	<u> Danuan</u>		3013 ty of Death	1220°M
Examine		Memor					ton	East				bot	
Funeral Director		5. Social Security N 212-24-3 Usual Residence	umber 806	6. Sex	7. A	ige (In yrs. Ia 86		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v. Year)	9. Birth Coui	place (State or Foreign ntry) MD
nd 2 should le filed within 72 hours after death with the Maryland leath and Mental Hygiene. Az is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at	Į.	10a. State	10b. County			10c. City	, Town or Loc	cation					10d. Inside City Limits
Maryl 28a-f otifie	Director	MD		1bot			Eas	ton					1X Yes 2 □ No
ith the	a D	10e. Street and Nur 3A Chad		rranc				10f. Zip Code 2160	1		10g. Citizen of USA	f What Cou	intry?
eath w	Funeral	11. Marital Status	WICK 16	12. \	Vas Deceden	t Ever in U.S	. 13. V	Vas Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Ra	ice - Ameri	
fter de amine	<u>۾</u>	1 Never Marr		ried	Armed Forces Yes 2 [Yes, Give	? □ No		f Yes, specify Cuba ☐ Yes 2 X No		rto Hican, etc.)	Specifi	ack, White,	etc. ite
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= 0		20a. Method of Dis 1 XBurial 2	Cremation		oval from Sta	te C	emetery, cren	sition (Name of natory or other plac		Date	20c. Location	-	
permit. Page 1 Department of Important: If I any injury or a once.		4 ☐ Donation 21. Signature of Fu				St.		h's Ceme			Cordo		
permit. Departrimporta		Jok	るる		ne Ro	ERO	$ \mathbf{r} _{20}^{\mathrm{Fe}}$	ellows, H 00 S. Har					Home, P.A.
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Physician/		Immediate Cause disease or condition resulting in death)		_ a	· /	hyo.	رمه کم د	I J	~ fore	Tion			Onset and Death
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ificate I	Nedio			d		1							
Attending Physician: The law requires that the death certificate be exerted. After this certificate has been signed by the attending physician is by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12			lf yes, outcom 1	n 2 🗌 Feta	Ideath 3	Ectopic pregnanc	р У			Date of deli Month	very Day Year
the at	ysic	1 Yes 2 Unknown	□ No		4 Pregnan 9 Unknow		leath 5 L	Other (specify)					Buy Tour
that the dea	by Ph	Part II. Other signi	ficant condition	ons contrib	uting to death	but not res	ulting in the u	underlying cause give	ven in Part I.	23e. Did 1	tobacco use co	ntribute to	the cause of death?
requires been sign should be	ted b									. 1 🗆	Yes 2 No	3 🗌 Pr	obably 4 Unknown
law requires been as been as 2 should	Completed									24a. Was		 Were aut prior to c death? 	opsy findings available ompletion of cause of
sician: The law certificate has irector, page 2:		25. Was case refer	rod to modical					00 D	of Doodh (Of	1 🗆 Yes	2 No		2 🗆 No
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		4 Homicide	determ		building,	njury - At no etc. <i>(Specify</i>))	eet, factory, office		28f. Location (ibei oi Huh	a noute wantber,
To the Hospital o within 24 hours af To the Funeral Di completely filled ir	Medical	/Check	Medical E	xaminer:	On the basis o	f examination	and/or inves	occurred at the time	on, death occurre	d at the time, date	and place, and o	due to the c	ause(s) and manner stated.
To th To th COMP	-	29b. Signature an	-		MO			29c. Licens			29d Date sign	ned (Month	, Day, Year)
			15/21	_	11110	•		1 2 8	24 02 6	720	Kinu	~ !	12,2012

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DHMH 17 Rev 06-2011

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State

And Company (Month, Day, Year)

JAN 17

Registrar

2012 32. gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 08, $p^{\,\mathsf{M}}$ 2012 3:57 Gerharz Elisabeth 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Year 933 1 □ M 2 🛣 F Hours SEP 03, Germany 78 579-50-8385 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Bethesda Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Germany 20817 8703 Burdette Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 12 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elisabeth M. (UNAVAILABLE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Webb Road, Cabin John, MD 20818 Margarita E. Gerharz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Life Legacy
Foundation 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/11/2012 Tucson, AZ 21. Signature of Funeral Service Licensee Name and Address of Facility
 Thibadeau Mortuary Service, p.a.
 7 Park Avenue, Gaithersburg, MD M00956 Park Avenue, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 DAYS CEREBELLAR HEORRHAGE disease or condition resulting in death) Due to (or as a consequence of)

Ph_sician/ Medical Examiner

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

ıral", or items 23a o Examiner must be

the Medical

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any rijury or other traumatic event, the Megines.

Director

Funeral

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Completed

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2

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

20

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3

1/8/12

Examiner Physician/Medical

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attending physician and for use as the burial-transit signed by the atte Completed page 2 s has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Be ည Certificate:

Sequentially list conditions, and, leading to him redicte cause. Enter Underlying Cause (Disease or linjury	b. HYPERTENSION Line I. (or as a consequence of):	1.			
hadse (Disease of Injury) hat initiated events esulting in death) Last	c. Due to (or as a consequence of):				
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of d	elivery Day	Year
art II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco			
DIABETES		1 🗆 Yes	2 X No 3 🗆	Probably 4	Unknov
CHRONIC OBSTRUC	CTIVE PULMONARY DISEASE	24a. Was an	24b. Were a	utopsy findi	

5 Pending

Investigation

determined

6 Could not be

1 ☐ Yes 2 🛣 No

27. Manner of Death

1 X Natural

2 Accident
3 Suicide
4 Homicide

Accident

25. Was case referred to medical

Hospital:

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury

28c. Injury at

1 🗌 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D0060117

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

performed? Yes 2 X No

28d. Describe how injury occurred

4 Nursing Home 5 Residence 6 Other (Specify)

death?

1 🗌 Yes

January 10, 2012

2 No

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my encintedge, death obtained at the time, date and plants, and due to the 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric J. Park, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar

10

Medical

31. Date filed (Month, Day, Year) JAN 17 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janice Graham January 2012 7:35 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17713 Vinyard Lane Montgomery Derwood Funeral Social Security Number . Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Min. (Month, Day, Year, une 20, Country) 232-54-4675 75 Director 1936 June West Virginia Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 should be filed within 72 hours after death with th and Mental Hygbers?
77 is marked other than "natural", or items 23: traumatic event, the Medic al Examiner must! 17713 Vinyard Lane 20855 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married δ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Teacher</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delbert Mills Genevieve Shoemaker and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan D. Graham (Spouse) 17713 Vinyard Lane, Derwood, MD 20855 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State . Page 1 1 D Burial 2 X Cremation 3 D Removal from State January 14, 2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, 10 East Gaithersburg, MD 2087 DeVol Deer Park Drive, M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗶 No 1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this nautifier. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) n 24 hours after death.

e Funeral Director: After this leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

State Registrar (Check

30. Name and addre

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JAN 17

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0035859

29d. Date signed (Month, Day, Year)

January 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Brandon	Edwar		1- For State	of Maryland	/ Depa	rtmei		alth an			giene	Reg. No.	20	112	2 0274
	Physici ! Exam	an/	Registrar 1. Decedent's Name (First, Middle,Las Brandon Edward He	•			-			- [2. Date of De Month January	ath			3. Time of Death 0220 hrs
			4a. Facility Name (if not institution, given 7335 Black Road					, Town, or irmont	Location o	of Death	· ·	40	c. County o		
	uneral irector		220-31-0443	9x 7. Ag	e (In yrs. la	st birthd	lay) If Ur Mor Yrs.	nder 1 Yea nths Day	_	Min.	8. Date of E			Foreig	hplace (State or n untry) MD
3	show any	5	Usual Residence of Decedent 10a. State 10b. County	ick	10c. City,	Town or									10d. Inside City Limits 1 X Yes 2 No
	n the Maryland 13a or 28a-f sho sotified at once.	i Director	10e. Street and Number 31 Pleasant Acre	s Dr.				Zip Code 788				10g. Citi	izen of Wha	at Coun	itry?
	and 2 should be lifed within 2 flows after death with the Analyzand tem 27 is marked other than "natural", or items 23s or 28s-f she traumatic event, the Medical Examiner must be notified at once	by Funeral		1 Yes 2 If Yes, Give Yeer or Dates:	No		3. Was Dece If Yes, spe 1 Yes	ecify Cubar	specify:	Puerto F	Rican, etc.)		White	, etc. Wh i	
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21215-0036	al Hygiene. ed other the it, the Med	Be Cor	17. Father's Name (First, Middle, Last)		<u> </u>						First, Middle				
212	nould be not a Mental is marked itic event,	To B	Charles Edward He 19a. Informant's Name/Relationship (T	rbert, Jr Type, Print)	•	17	Mailing Addre		et and Num	ber or Ru		umber, C	ity or Town		
MD.	and 2 should lealth and M tem 27 is m traumatic		Charles Herbert,	Jr/fathe	20b. P	lace of [Pleasa Disposition (N	lame of ce		Dr.,	Thurn				38 Town, State
more	ent of H nt: If i		1 X Burial 2 Cremation 3 A Donation 5 Other Specify		310	•	y or other plac Ldge Ce	,	rv	01/2	0/2012) Ti	nurmoi	nt.	MD
Baltimore,	permit. rages I and 2 should be permit of Health and M Important: If item 27 is minjury or other traumatic		Signature of Funeral Service Licer	isee	IDIU	e n.									MD s, P.A.
Phy	sician		23a. Part I. Enter the disease, or comp failure. List only one cause on ea		the death.	Do not e									21702 Approximate Interval Between Onset and
	ledical aminer		Immediate Cause (Final disease a.	Head and Neck		١٠									Death
			Sequentially list conditions, b.												
		Examine	cause. Enter Underlying Cause (Disease or Injury that initiated	Due to (or as a conse											
	an and al - transit	Exa	events resulting in death) Last d.	Due to (or as a conse	equence or):									
	15 E	edical	UNPENDED	AMENDED								100			
Box 68760,	e attending physici for use as the buri	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown		2	Fetal deat		Ectopic	pregnan	су	23	d. Date of d Month	-	ay Year
P.O.	signed by the be detached	þ	Part II. Other significant conditions	contributing to death	n but not re	sulting ir	n the underlyi	ng cause (given in Par	rt I.		_	use contrib		he cause of death?
of Vital Records, P.O.	ine law requi cate has been page 2 should	Completed								_	peri 1 ✓ Yes	opsy formed?	pr de		opsy findings available ompletion of cause of S
/ita	this certificate	B	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatie	nt 2 🗌	ER/Outp	patient 3	_	of Death (Reside	ence 6 🗸	Other	Scene
on of	eath. or: After the funeral of	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of Inju FOUND: Jan 14, 2012	ear)	28b. Tin FOUN 0200 h			ry at Work?	le le	28d. Describe Passenger				uring collision
Division	within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not determine	be 28e. Place of In	jury - At ho		n, street, facto	ory, office b	ouilding, etc		28f. Location or Town, 335 Black				al Route Number, City
	within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examiner	ian: To the best of m r:On the basis of exal and manner stated.											
	vit To	Me	29b. Signature and title of certifier	- PCC)	~	2	9c. Licens					Date signe	•	th, Day, Year)
	9		30. Name and address of person who Patricia Aronica-Pollak MD				er 900 V	V. Baltir	nore Str	eet, Ba	altimore, M	VID 212	223		
	S Regis	tate	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	е	back	, ,		•					

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla	-			ental Hygi	ene	0 00715
			State Registrar	Cer	tificate of Dea	ath		g. No. 2	2 02/45
	Physicia		1. Decedent's Name (First, Middle, Last) Frederick Horn Jr.			İ	2. Date of Death Month	Day Ye	
4	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death	January	4c. County of [Death
	LAGITIII	C1	2312 Ross Road		Silver Sp	ring		Montgom	ery
	Funeral		017 70 0010	rs. last birthday)		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	(ear)	Birthplace (State or Foreign Country)
la	Director		217-70-8213 Usual Residence of Decedent 1 ★ M 2 □ F 56	Yrs.			07/04/19	55 W	ashington, DC
	and show	ro		City, Town or Lo	cation	<u> </u>			10d. Inside City Limits
	Maryl 28a-f otifle	Director	MD Montgomery	Silver S					1X Yes 2 □ No
	th the 3a or t be n		10e. Street and Number 2312 Ross Road		10f. Zip Code 20910			nited St	
	ath wi	Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13. \	Was Decedent of Hispa	nic Origin? (Spec	cify Yes or No-	14. Race - /	American Indian,
9	ter de	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		if Yes, specify Cuban, M 1 □ Yes 2🌠 No S		Rican, etc.)	Black, V Specify: W	White, etc.
003	ours af tural" al Exa	Completed	3 ☑ Widowed 4 ☐ Divorced Year or Dates.					16b. Kind of Busin	
15-	n 72 hc an "na Medic	mple	(Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done durin O NOT use retired)	ng most of workir	ng		
212	within giene. er tha , the I		Elementary/Secondary (0-12) College (1-4 or 5+)	Lands	scape Archi	tect		Horticul	.ture
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2 be notified at other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Frederick Horn		18		(First, Middle, Mi Edmundso		
r <u>yla</u>	d Men marke marke		19a. Informant's Name/Relationship (Type, Print)	10h Mailie	ng Address (Street and			_	e Zin Code)
Ma	12 shouth an and 27 is retrau		Frederick Horn / Father		Horn Road			-	, _, _ ,
ore,	ige 1 and nt of Hea t: If item		20a. Method of Disposition	b. Place of Dispo	matory or other place)	01/17	1	20c. Location - Cit	-
im	ment tant: I		4 Donation 5 Other (Specify)	National	l Crematory			alls Chu	
Baltimore,	permit. Page 1 Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address o				
			23a. Part 1. Enter the disease or complications that caused the d		5130 Wiscon				Approximate
1	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death Inuces
3	Medical		resulting in death) a. Due to (or as a cons	sequence of):					
-	Examiner	7	Sequentially list conditions, b. Aortic Val	ve Dise	ase (Biscus	spid Aor	tic Valv	7e)	5 Years
	Dei se	Examiner	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury Prosthetic		Valves				5 Years
	so that the death certificate be executed igned by the attending physician and be detached for use as the burial-tansit	Еха	that initiated events resulting in death) Last c. Trostnettet		Vaives				
90	e be e ysicial ne buri	dical	d						
6876	rtificat ing ph e as th	/Med	IF FEMALE:						
Box 6	ath ce attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
B.	he de	hysi	1 Yes 2 No 4 Pregnant at time 9 Unknown						
P.O.	that 1	by P	Part II. Other significant conditions contributing to death but not	t resulting in the ι	underlying cause given	in Part I.			ute to the cause of death?
ds,	been sig	ted	Alcoholism						Probably 4 Unknown
Records,	The law re cate has be page 2 sh	Completed					24a. Was ar autops perform	v prio	re autopsy findings available or to completion of cause of ath?
I Re	iclan: The certificate rector, pag		25. Was case referred to medical		26 Place	of Death (Check	perform	2 ♣ No 1 □	Yes 2 No
of Vital	ysiclan: s certific director,	To Be	examiner? X Hospital:	ER/Outpatie	Other:			nce 6 🗆 Other (Specify)
of	ding Phy h. After thi funeral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year	28b. Time o	work?	1	28d. Describe ho	w injury occurred	
ion	Attendii er death. ector: Ai by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	At home form at		s 2 No	29f Location (Str	reet and Number of	or Rural Route Number,
Division	I or Attendi after death Director: A d in by the f		4 Homicide determined building, etc. (Spe	ecify)	reet, factory, office		City or Town		in Hural House Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and appropriately filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my kr (Check 2 Medical Examiner: On the basis of examin	nowledge, death	occurred at the time, d	late and place, and	nd due to the cau	se(s) and manner	as stated.
	the H the Fi	Mec	only one) 3 Certifying Nurse Practitioner: To the best	t of my knowledge	e, death occurred at the t	time, date and pla	ace, and due to the	e cause(s) and man	nner as stated.
	P ∰ P ∰		29b. Signature and fitte of certifier	M	29c. License nu MD 308			9d. Date signed (h	
	•		30. Name and address of person who completed cause of death ((Item 23a) (Type.		Goldbau	ım ND		
			5530 Wisconsin Ave. Suite 5	15 Chevy	Chase, MD				
	Sta		31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	while.				
	Registr	वा	WHITE AT LUIL CERUM	HI A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Mary 13, Hayunga January 2012 2:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpiac Country) NJ Months 1 M 2 M 2 Hours (Month Day, Year) 1922 100-16-7919 **Director** 89 May Usual Residence of Decedent iffied within 72 hours and tall Hygiene.
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10603 Wheatley Street 20895 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Specify:White Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Case Worker City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Zets Elsie Trejfa permit. Page 1 and 2 should be Department of Heaith and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene G. Hayunga/Son 10603 Wheatley Street, Kensington, MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Most Holy Campton of the place Holy Campton of the place Holy Cemetery 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Jan, 17, 2012 4 Donation 5 Other (Specify) Brooklyn, New York 21. Signature of Funeral Service Licenses Francis Adress Corina Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ e disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner ubitus olcer with osteomelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death the 9 Unknown Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 0 No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 👰 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 🗆 Yes 2 🗆 No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a, Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle of certific 00050612 10 mall 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Rockuille 6 MALIER MD 701 Veirs AMUEL

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

Year

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		4	State of Maryland / Dep	artment of Health a artificate of Death		0010	0271.7
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	n/	Mary Jane Hannum		Month	Day 2012	3:30 PM
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	f Death	4c. County of Deat	
ne-se ^c	-		Montgomen General Hospital 5. Social Security Number / 16. Sex 17. Age (In yrs. late birthday)	If Under 1 Year If Under 2	24 Hrs. 8. Date of Birtl	Mentgo.	thplace State or Foreign
	Funeral Director		215-14-7424 1 □ M 2 🖾 F 91 Yrs.	Months Days Hours	Min. (Month, Day	(Year) Co	untry)
	d ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ncation	June 16	, 1920 Vir	ginia 10d. Inside City Limits
	arylan a-f sh fied a	유		Spring			1 ☐ Yes 2 🕅 No
	or 28		10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	n with	Funeral	2604 Cory Terrace	20902		United Stat	
	r death		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces 1. In □ Yes 2 □ No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, Whit	
036	s afte ral", c Exarr	Completed by	3 ★ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
2-0	2 hour	plet	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most	of working	16b. Kind of Business.	/Industry
121	ithin 7 ene. r than	Com	Flementany/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired) memaker		Own Home	
d 2	filed walled wal	Be	17. Father's Name (First, Middle, Last)	18. Mothe	er's Name (First, Middle,	Maiden Surname)	
ylaı	should be file and Mental I 7 is marked o raumatic eve	욘	Benjamin Thomas Powers		mi Doshie G		
Maryland 21215-0036	2 shouth and the and the and the and the traum			ling Address (Street and Numbe Cory Terrace,			
	1 and 2 sl of Health a item 27 is other tra		20a. Method of Disposition 20b. Place of Disp	position (Name of ematory or other place)	anuary 16,	20c. Location - City or	Town, State
imo	Page ment o ant: If ury or		Burial 2/Li Cremakijin 3 Li nemovarimin/State	coln Cemetery	2012	Brentwood,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	İ	21. Signature / Fineral Ferrice Les see	Prancis J. Col. Francis J. Col. 500 University	lins Funera Blvd. W.,	l Home, Ind Silver Spri	ing, MD 20901
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as	cardiac or respiratory an	rest, ,	Approximate Interval Between Onset and Death
八	Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	my teulur	e		Onoct and Dodg.
~	Examiner		Due to for as a connequence of):	rather			
	- ±0	iner	Beguaritally list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	1			
	and	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):				
0	physician and the burial transit	dical	d d				
3760	ificate ig phy as the	Medi	IF FEMALE:				
39 ×	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of de Month	elivery Day Year
. B	the at	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)			
P.O. Box 687	Attending Physician: The law requires that the death certifics or death. sctor: After this certificate has been signed by the attending p by the funeral director, pcge 2 s rould be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the		111	obacco use contribute t	. "1
ds,	quires en sig ould b	ted	<u>Serzure</u>				Probably 4 Donknown
Division of Vital Records,	law ra has be	Completed by	Seizure Chronic Kichez direar	*	24a. Was auto	psy prior to death?	
E B	sician: The lar certificate ha irector, page?	င္ပ	25. Was case referred to medical	26. Place of Dea	th (Check only one)	2 1 Ye	es 2 11 No
Vita	Physician: this certific al director,	To B	examiner? 1 Yes 2 ER/Outpat	ient 3 🗌 DOA Other: 4 🗌 No	ursing Home 5 🗆 Resi	dence 6 Other (Spe	cify)
J Of	ing Ph		27. Manner of Death 1	work?		now injury occurred	
sior	Attend death ctor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined		28f. Location (S	Street and Number or R	ural Route Number,
Ŏ <u>X</u>	al or A s after al Dire		4 Homicide determined building, etc. (Specify)		City or Tov	vn, State)	
_	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi gompletely filled in by the funeral	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death or	ccurred at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the F within 24 To the F complet	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowled	ge, death occurred at the time, da 29c. License number	ate and place, and due to	the cause(s) and manner 29d. Date signed (Mon	as stated.
	F = 12		> H. A. Mariner	70071	314	1/12/12	
			30. Name and address of person who completed cause of death (Item 23a) (Type Manju Mavanur, M.D., 18101 Prince Ph	, Print)			
	C.				y, maryiano		
	Sta Registr		31. Date filed (Month, Day, Year) SAN 1 7 2012 Registrar's Signature	West.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For _ State	State of Maryland / Department of Health and Mental Hygiene 2012 02							02748		
			Registrar 1. Decedent's Name (First, Middle,	Certificate of Death					2. Date of D	Reg. No. 2. Date of Death 3. Time of Death			
	Physicia		Edwin Ki:			າຊ			Januar	onth Day Year			
	Medic Examin	_	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Dea				4c. County of Death			
À	<i>).</i>	Ш	Northampton 1				Frederi		- 1 - 5 - 75		Freder		
	Funeral Director		5. Social Security Number 232-42-6176	6. Sex 7. / 1 □ ★M 2 □ F	Age (In yrs. Ia 82		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, D	ay, Year)	Cour		
			Usual Residence of Decedent	AVI Z L T		Yrs.			Jan.3	, 1930		ginia	
	ryland -f sho ied at	Director	10a. State 10b. County Maryland Frederick			10c. City, Town or Location Thurmont				10d. Inside City Limits 1 ☑XYes 2 ☐ No			
	or 28a	Dire	10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?			
	1 and 2 should be filed within 72 hours after death with the Maryland freath and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	13503 Catoctin Hollow Rd.			21788				US.	A		
		Fun	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S		/as Decedent of His Yes, specify Cubar)- 1	4. Race - Americ Black, White,		
36	after al", or Exami	d by	Armed Forces 2 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates.			1	☐ Yes 2 🛣 No	Specify:		8	Specify:	White	
Ö	hours natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working)				na 16b. Kind of		f Business/Industry	
21	hin 72 ne. than "	ome	Elementary/Secondary (0-12) College (1-4 or 5+)			life. DO NOT use retired) Technician				Plumbing			
22	ed wit Hygier other i	Be C	Z 17. Father's Name (First, Middle, Last)				18. Mother's Name			(First, Middle, Maiden Surname)			
lan	l be fil fental rked c	٩	James King				Virginia Ban				kcroft		
Maryland 21215-0036	should and N is ma auma						19b. Mailing Address (Street and Number or Rural Route Nur				nber, City or Town, State, Zip Code) ., Thurmont, MD 21788		
ტ` ტ`	and 2 Health em 27 ther tr		Joanne King /	Wife	Took D	-		ctin Ho		7			
nor			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	ate Roc	Place of Disposition (Name of cemetery, crematory or other place) cky Hill Cemetery 1/1			19/2012	Date 20c. Location - City or Town, State Woodsboro, Maryland				
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L		,		Name and Addres	s of Facility			eral Hom		
<u>~</u>	a la la la la la la la la la la la la la		1 our trey	Stauf	h		1621 0	possumt	own Pike	, Fre	ederick,	MD 21702	
			23a. Part 1. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death										
~]	Ph, ician/ Medical		Immediate Cause (Final disease or condition resulting in death) ACCIOENT Onset and Death 1-2 Days a. Due to consequence of the consequence of th									1-2 13945	
	Examiner			Due to (or a	Due to (or as a consequence of):								
		iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. pue to (or a	Due to (or as a consequence or).								
	scuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ience of):	e of								
	be exe	dical	resulting in deathy East		Due to (or as a consequence of):								
3760	death certificate be executed ne attending physician and ed for use as the burial-transi	Medi	ve service	- d.		- 1874						-	
x 68	h certi tendin or use	lan/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						2	23d. Date of deliv	very Day Year	
Box	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown							Month Day real		
P.O.	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause								the cause of death?		
ds,	quires an sign	ed b									1 Yes 2 No 3 Probably 4 Unknown		
Sor	aw rec as bee	Completed						24a. Was an 24b. Were autopsy findings avail prior to completion of caus		opsy findings available ompletion of cause of			
Re	sician; The law is certificate has k										2 🗆 No		
ita	sician certifi irectol) Be	25. Was case referred to medical examiner? 1 Yes 2 DNo Hospital:										
of \	g Phy er this neral d	te: To	27. Manner of Death	28a. Date of i	injury								
on	To the Hospital or Attending Physician; The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	fica	1 Matural 5 Pendir 2 Accident Investig 3 Suicide 6 Could	gation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No								
Division of Vital Records,		Certificate:	4 Homicide determ							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Ω		Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	the Ho nin 24 the Fu	Med	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Conflying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	7 Vit		29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) D26499 1-16-12										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									0			
Ronald Miller MD, 4 Culwell Drive, Mt. Airy, MD 21771													
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature										
	Registr	वा	OVIN TO	LUIL /4	The safe and the safe and and and and and and and and and and	10. 14							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ HARL ES Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Seasons Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 8/16/1938 Country) 213-34-8140 73 **Director** 1 🗶 M 2 🗆 F MD Yrs 28a-f show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State death with the Maryland Director MD Baltimore Reisterstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Hammershire Road 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: white Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Local Steamfitters t of Health and Mental Hygiene.

If item 27 is marked other than
or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) steamfitter & Plumbers 486 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles H. Klaus, Sr. Frances Brophy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zondra Raye Klaus wife 306 Hammershire Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2XX Cremation 3 🗆 Removal from State ō Department of Important: If any injury or 1/11/2012 Hampstead, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 24 mon disease or condition resulting in death) Medical ue to (or as a consequence o Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying.
Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown After this certificate has been signed by a funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) (Specify မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Medical Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 2 Accident injury 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

WJL

To the

only one) 29b. Signature

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day O 8 Month 10:39 George 2012 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 😿 M 2 🗆 F NOV 17, Year 944 220-40-9265 67 MaryTand **Director** Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Taneytown Carroll Maryland 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 5584 Rickell Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \sum No 962— If Yes, Give 1970 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ۾ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white 1970 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy Tine George Kreit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5584 Rickell Road, Taneytown, MD 21787 Elaine Cassidy, companion Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of I any injury or 1 X Burial 2 Cremation 3 Removal from State St. Joseph Cemetery 01/12/2012 Taneytown, MD 4 Dopation 5 Other (Specify) 21. Signatu e of Foneral Service I 22. Name and Address of Facility 22. Name and Address of Facility Myers—Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MCA stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performe death? Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending s after death. 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 1558651331 WJL 2012 M.D. 6+1VA

State Registrar

ODD 31. Date filed (Month. Day

DHMH 17 Rev 7/2009

South Green steet Baltmore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

JAN 1 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Year Physician/ 11, 9:15 РМ January Anne M. Kyler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Capitol Heights 5611 Sheriff Road 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** 7. Age (In yrs. last birthday) Months 1 - M 2 - F Hours Mir DC ĭ957 Director 578-80-6268 55 Jan. Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 X Yes 2 ☐ No Capitol Heights Prince George's Maryland 10g. Citizen of What Country? 9 10e. Street and Number 10f. Zip Code the Medical Examiner must be items 23a Funeral United States 20743 5611 Sheriff Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Nas Deceue... _ Armed Forces? ¹ ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 → No Specify If Yes, Give Year or Dates Specify: "natural", **Black** 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Engraver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ೭ Audrey Wallace Samuel E. Powell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 5611 Sheriff Road Capitol Heights, Maryland William R. Kyler - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 21, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2012 Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, nknown disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): iding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) be detached g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man r of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 29a. Certifier

(Check

only one) 29b. Signature and

30. Name and address of person

To the Hosp within 24 hor To the Fune completed fi

BASIL

who completed cause of death (Item 23a) (Type, Print)

9200

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 01-18-2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Khour 2012 10 2070 Medical anuar! 4a. Facility Name Visiot institution, give street and 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Johns Hopkins Hospita 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Days Min (Month, Day, Year) Director 25-96-4248 1 🕅 M 2 🗆 F 60 <u>October 10,1951</u> Lebanon Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 ☐ Yes 2 X No Fairfax VA Annandale 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7864 Newport Glen Pass 22003 USA items Page 1 and 2 should be filed within 72 hours after death al Hygiene. of other than "natural", or items event, the Medical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Businessman traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ၉ Susan Petros Salim Khoury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 14580 Croatan Drive, Centreville, VA 20120 Tony G. Khoury, Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 01/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Annandale, Virginia 21. Signature of Faral Service Licensee 22. Name and Address of Facility Everly Community Funeral Care 6161 Leesburg Pike, Falls Church, VA 22044 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic squamous cell disease or condition cancel Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last inding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be east hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) <u>RES-000</u> 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANDEY

State Registrar 32. Registrar's Signature

600 N. Wolfe St Baltimore Maryland 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January Physician/ 12^{pay} 2012 THOMAS E. LEWIS 5:15 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg Wilson Health Care Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthdav) Social Security Number **Funeral** Countainio Days Hours March Day Year) 1915 1 🛣 M 2 🗆 F 160-16-1845 96 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy igury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 301 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Louise Peckinpaugh Chauncey B. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Dare Drive, Elkton, MD 21921 Kenneth A. Lewis (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery crematory or other place) Metropolitan Crematory January 13 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2012 Alexandria, Virginia 22. Name and Address of Facility Devol Funeral Home 21. Signature of Funeral Servi M00689 10 East Deer Park Dr. Gaithersburg, MD 20877 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, research tarture. List only one cause on each line. Approximate Interval Between 23a. Par 1 month Immediate Cause (Findisease or condition resulting in death) se (Final Congestive Heart Failure Physician! Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last bunial nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav for Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 🗌 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has 1 ☐ Yes 2 ☐ No Yes 2 X No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Example Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) title of certifie 29c. License number 29b. Signature a 3 January 12, 2012 D19294 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20879 Gaithersburg, MD John R. Melnick M.D. 911 Russell Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Boy King Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:09 PM January Peom Gi Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospita Prince George's Laurel 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Unde 8. Date of Birth **Funeral** Months Days 1 X M 2 🗆 F Hours 02/02/1936 Country) Korea 15 Director 216-92-1013 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant I file 27 is marked of other than "natural", or items 23a or 28a-f sho ury or orher traumatic event, the Medical Examiner must be notified at ury or orher traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Greenbelt Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20770 U.S.A. 7834 Somerset Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Asian 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vending Machine Business Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ In Soo Chuna Seok На Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7834 Somerset Court, Greenbelt, Maryland 20770 Yong Lee - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem. Gardens 01/14/2012 | Davidsonville. MD 4 Donation 5 Other (Specify) . Signature of Dineral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HyperKalemia disease or condition resulting in death) Medical **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or iinjury Examiner Stransi Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician use as the buria Acute Respiratory Failure Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for 4 Pregnant Month Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performe Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ျ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Medical Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury n 24 hours after death e Funeral Director: A eleted filled in by the fi Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune
completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 7300 Van Dusen Roac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional N. Shanmugam, MD Hospital Date filed (Month, Day, Year) State JAN 17 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Norma Physician/ Molali Month 18-20 2 0035 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Cify, Town, or Location of Death 4c. County of Death HCパらのたd Harford Memorial Hospital Havre de Grace 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🂢 F 86 Months 1 10 nth 3 ay, 1 9 2 5 MESERGand **Director** ar-20-3897 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland other traumatic event, the Me lical Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 28a-f Maryland Harford Havre de Grace 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a United States of America 1500 Iriquois Court 21078 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Familii Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank J Fuchs pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Maryland 21078 4007 York Drive Havre de Grace W. Frank Molali (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Trinity Comotory 01/21/2012 Churchville Marghand 4 Donation 5 Other (Specify) Synatury of Funeral Service Licensee 22. Name and Address of Facility ZCLLMCII. functio. Washington St Havre de Grace MornEand Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director; After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 E HO 1 Yes မှ 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Matural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined e Funeral E 1 Destifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination arror investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of gertifie 29c. License number 29d. Date signed (Month, Day, Year) 20215 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 md 21078 Si Umian are K-ORMA. 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:05am Matherly **Physician** Waneeda Faith 2012 January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Manchester Tong View Nursing
Decial Security Number 6. Sex Age (In yrs. last birthday) Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Funeral** 1 □ M 2 🔀 F 233-24-4523 9/2/1920 WV **Director** Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If the m 27 is amarked other than "natural", or items 23a or 28a-f show Important: If the m 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modified Examinar mast be notified at any injury or other traumatic event, Carroll Hampstead 1 Yes 2 No MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21074 4428 Black Rock Road, Apt. 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married white Specify: 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ 3X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) nursing registered nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matilda Ella Ogden George Anderson Poteet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2205 Fairmount Road, Hampstead, MD 21074 Roberta Taylor, daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Meadowridge Memorial 1/9/2012 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral HOme 21. Signature of uneral Service Licensee MO0741 934 S. Main Street, Hampstead, MD 21074 Venner land Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Edin **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed ing physician and as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy certificate has birector, page 2 s 2 No 1 ☐Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this After this funeral o 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation n 24 hours after death.

Funeral Director: A pletely filled in by the filled in the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Fune

completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

WIL 2

> State Registrar

Jef Nedis Mt 2835 31. Date filed (Month, Day, Year) 9 2012

30. Name and address of person who completed c

JAN 0

32. Registrar's Signature

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eleanor Elizabeth Moore 01/09/2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Southern Maryland Hospital Prince George's Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Hours 213-26-8443
Usual Residence of Decedent Director 1 □ M 2X F Yrs 12/18/1926 MD show or 28a-f shown notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Howard Columbia 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō ms 23a or must be r Funeral 7070 Cradle Rock Way, #328 USA 21045 items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter Armed Forces? þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Completed 3 Widowed 4 XDivorced Black Year or Dates Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien
27 is marked other the Research Animal Husbandry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Irene Kelly Leroy Cooper and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5102 Cheshire Land, Lanham, MD 20706 Eric Moore/son 27 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hopkins UMC Cem. 01/16/2012 | Highland, MD Funeral Service Liotn 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician arrest Cardiopulmonery Second disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ocardial MINHES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician street Physician/Medical Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month for Day Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 9 No 1 Inpatient 2 FR/Outpatient 3 DOA this After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours are decth.

To the Funeral Director Affer
Completely filled in by the funeral 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 10068207

Registrar

State

Pd. Clinton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

JAN 17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 06, 201^{Year} Mikhaylovskiy 7:15 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 6. Sex 1 ፟፟፟ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. JAN 06. Director T929 Russia 212-45-8664 83 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medir al Ex. miner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 XNo Specify. 3 Divorced 4 Divorced Specify: Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other tl Pilot Trainer Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mikhaylovskiy (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 308 W. Edmonston Dr., Rockville, MD 20852 Svetlana Nezhalskaya / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 01/11/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD M00956 23a. Part inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ lung Cance disease or condition Medical resulting in death) Due to (o s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Disease or impury that initiated events Due to (or as a consequence of) and --that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? 5 Other (specify) Month Day Vear 1 Yes 2 No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy e Hospital or Attending Physician: The 124 hours after death.
9 Funeral Director: After this certificate I leted filled in by the funeral director, page performed' death? 1 ☐ Yes 2 🗙 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 **N**0 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 - Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Division of Vital

Montrose Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6121

1-7-2012

Rockville

12-00625

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darwish Moghbe		S 1- For State Registrar	tate of Maryl		partment d ertificate d		d Ment	al Hygi		eg. No.	0	2 0275
Physicia Medical Exami	in/	Decedent's Name (First, Mid- Darwish Mog							Date of Dea Month anuary 2	ith	ar	3. Time of Death 2058 hrs
		4a. Facility Name (if not instituti 12544 Seavolt Road		umber)		4b. City, Town, or Hancock	Location of			4c. County Washin		
Funeral		Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Yea	ar If Under	24Hrs. 8	Date of Bir	rth(MM/DD/YYY	Y) 9. Birt	
Director		188-64-8132	1XM 2F		27 Yr	Months Day	s Hours	Min.	7/04/	/1984	Foreig Co	n untry) PA
y w		Usual Residence of Decedent 10a. State 10b. County	,	Inc. C	ity, Town or Loca	tion	_					10d. Inside City Limits
			nington		Hagerstown							1 X Yes 2 No
Aarylar 28a-fs 3 at op	Director	10e. Street and Number			10f. Zip Code					0g. Citizen of W	hat Cour	ntry?
death with the Maryland or items 23a or 28a-f show must be notified at once.		455 Jonathan			21740					US		
ath wil	Funeral	11. Marital Status 1 X Never Married 2 N	Married Armed F		lf `	as Decedent of His Yes, specify Cubar					e - Ameri te, etc.	can Indian, Black,
ifter de	by Fu	3 Widowed 4 Di	1 Yes ivorced If Yes, Give Ye	2 X No 1 Yes 2 X No specify:						Specify:	Whi	te
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5-0036 lled within 7 Hygiene. I other than	등	17. Father's Name (First, Middle			DI3aDI		18.Mother's	Name (Fir	st, Middle, I	Maiden Surname	∍)	• •
2121 Mental De fin marked c event,	8	Abdo1hamid M 19a. Informant's Name/Relation	0		10h Mailin	g Address (Stree			oertz		un Stata	Zin Codo)
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re, N 11 and FHealth fitem er trau	Ì	20a. Method of Disposition 1 Burial 2 X Crematic				sition (Name of ce		Da		20c. Location		
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ł	24. Signature of Funeral Service	e Licensee	M002		Name and Address				st Main		
Physician	┪	23a. Part I. Enter the disease, of failure. List only one cause				ove Fune the mode of dying,	such as car	rdiac or res	Piratory arr	est, shock, or he	eart	Approximate Interval Between Onset and
/ /Medical Examiner		Immediate Cause (Final disease	e a. Complicat		vns Syndrom	е						Death
		or condition resulting in death)	Due to (or as b.	a consequence	e of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence	∋ of):							
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	C	a consequence	e of):							
i 0, e be executed ysician and burial - transit	dical	UNPENDED	d AMENDED									
60, ate be exphysician	- Ψ-	IF FEMALE:		outcome of pr	egnancy					23d. Date o	f delivery	
Box 6876C e death certificate is the attending physed for use as the b	cian/	23b. Was decedent pregnant in t past 12 months?	I I LIVE	birth nant at time of	H	etal death 3 ther (Specify)	Ectopic i	pregnancy		Month	C	ay Year
BOY e death the atte	Physician/M	1 Yes 2 No 9 Ur	3 Oliki									
Division of Vital Records, P.(). Box 6876(the Hoopinal or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending phy- ripletely filled in by the funeral director, page 2 should be detached for use as the b	2	Part II. Other significant condi	tions contributing	to death but no	t resulting in the	underlying cause (given in Part					the cause of death? ably 4 Unknown
ords, w require s been si	eted			_					24a. Was autop			topsy findings available ompletion of cause of
Recol The law cate has	Сошріс		<u></u>						perfor		death?	
Vital Re- rsician: The nis certificate director, page	BeC	25. Was case referred to medical examiner?	al Hospital:				of Death (C					
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Divis Fospital or A 4 hours after cuneral Dire y filled in b	3	29a. Certifier	Physician: To the be		edge death occu	rred at the time, da	ate and plac	e and due	to the caus	se(s) and manne	r as state	
Di To the Hospital of within 24 hours a To the Funeral I completely filled	edical	(Dilouit only —	aminer: On the basis and manner	of examination	-							
	ž	29b. Signature and title of certifi				29c. Licens				29d. Date sign		
		30. Name and address of person	n who completed co-	ise of death /14	em 23a\	O.C.	IVI.□.			January 23	5, 2012	
31		Donna M. Vincenti, N				W. Baltimore	Street, E	Baltimore	e, MD 21	223		
St	ate	31. Date filed (Month Bay, Year	2012 32	egistrar's Signa	ature	11					~	

C.

2-00655		Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are Le	gible.	
Sean McLaughlin	4	State of Maryland / Department of Health and Mental I	Hygiene	201	2 0276
	R	egistrar COTIMOGIC OF DOGIT	2. Date of Dea	eg. No.	3. Time of Death
Physician. Medical Examine	' I	I. Decedent's Name (First, Middle,Last)	Month January 2	Day Year	0953 hrs
, and the same		SEAN FRANCIS McLAUGHLIN (a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Deat	1
- Land		University Hospital Baltimore			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		rth(MM/DD/YYYY) 9. Bi	
Director	1	215-96-9439 1X M 2 F 42 Yrs. Months Days Hours N	^{lin.} 3–26–	-1969	puntry)WASH.,D.
	t	Jsual Residence of Decedent			Land to the City Limits
any .	1	10a. State 10b. County 10c. City, Town or Location			10d, Inside City Limits 1 Yes 2 No
faryland 28a-f show 1 at once.	5 L	MD. ANNE ARUNDEL ANNAPOLIS		0g. Citizeri of What Cou	
the Maryland a or 28s-f sh tified at once	3 1	10e. Street and Number 10f. Zip Code	[]		iiu y ?
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or items 23		1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	White, etc.	iouri iridiari, bioos,
er dez		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: WH]	.u.E.
is aft	<u>?</u> -	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	of work done	16b. Kind of Business	
2 hou	<u> </u>	Elementary/Secondary (0-12) College (1-4 or 5+)			
5-0036 lled within 72 hours Hygiene. lother than "natu the Medical Exan		12th MECHANICAL SER.ENG		HVAC	
5-0 led wi	3 -	17. Father's Name (First, Middle, Last) 18.Mother's Na	me (First, Middle, I	Maiden Surname)	
21215-0036 yuld be filed within 72 hours after in Mental Hygiene. marked ofter than "natural", ie event, the Medical Examine: To Re Commissed by		FRANCIS JOSEPH McLAUGHLIN, JR. ELIZ	ABETH A	ANN RICARI)S
AD 21215 2 should be file 1 and Mental H 27 is marked matic event, I	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of			
ore, MD 2 ss 1 and 2 shou of Health and N if item 27 is in her traumatic		ELIZABETH McLAUGHLIN-MOTHER 12180 MANOR CT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City o	Town, State
Ore ges 1 a of He		1 X Burial 2 Cremation 3 Removal from State ST.MARY S CEMETERY 1	_30_12	BRYANTOV	IN MD
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Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	c or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on eachtifie. Immediate Cause (Final disease a. Multiple Injuries			Death
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K 68		past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
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ding Ph		1 Natural 5 Rending (Month, Day, Year)		t fell from	roof
IVISION I or Attend after death. Director:		2x Accident Investigation 28e Place of Injury - At home farm street factory, office building, etc.	2Bf. Location	(Street and Number or R	ural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Pactaurant	or Town, Annapo		ural Route Number, City
ig of pi	<u>3</u>	29a, Certifier A Continue Rhysisian, To the heat of my knowledge, death occurred at the time, date and place a			ited.
the F thin 2-	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, date	e and place, and due to	he cause(s)
F N F S	Ĕ	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
		O.C.M.E.		January 26, 201	12
	ŀ	30. Name and address of person who completed cause of death (Item 23a)			
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Ba	Itimore, MD 2	1223	
Sta	te	31. Date filed (Month, Day, Year) 2012 32. Fegistrar's Signature			
Registra	ΞU	FEBU 22012 Thouse B. Marie			

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12^{Day} 2012 Thanh Huong Nguyen January 7:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 27, 1930 **Funeral** Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours Min. 220-11-2062 81 Vietnam **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 7306 Waterloo Walk 20707 Vietnam Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 K No Specify. 3 Midowed 4 Divorced If Yes, Give "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Chef ed other i Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hoanh Ha Le Vinh Thi Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Anh Tuyet Phan/Daughter 7306 Waterloo Walk, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or oth Parklawn Memorial Parklawn Memorial Park Jan. 18 2012 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 18, 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 22. Name and Address of Facility
Francis J. Collins Funeral
500 University Blvd. W., S 21. Signature of Funeral Service Licenses Home Inc. In ble C MYA MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciany disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AL Sequentially list conditions, Examine if any, leading to infinediate cause. Enter Underlying Due to (or as a consequence on) sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the b IF FFMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 No 4 ☐ Pregnant the detached is been signed by the should be detached To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director, After this provided filled in beautiful provided filled f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Premirrana performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			101	te of Maryland / Dep			ntal Hygiene	012 02762
		_	State Registrar	Ce	rtificate of De		Reg. No.	
	Physicia		Decedent's Name (First, Middle, Last)				Date of Death Month MYCOV Day	3. Time of Death 6:16 P M
34.	Medic	al .	John B. Ott, Jr 4a. Facility Name (if not institution, give street an		Ab City Town or lo		/1	nty of Death
	Examin	φı :	Meritus Medical Ce	·	4b. City, Town, or Lo			nington
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year It	f Under 24 Hrs. 8, [Date of Birth	9. Birthplace (State or Foreign
	Director		217-28-1052 1 M M 2	□ F 80 Yrs.	Months Days		(Month, Day, Year) /14/1931	Maryland
	p wo t		Usual Residence of Decedent 10a. State 10b. County	10c, City, Town or L	ocation		, ,	10d. Inside City Limits
	ırylan 1-f sh ied a	cto	MD Frederick					1 ☐ Yes 2 🕱 No
	or 288	Director	10e. Street and Number		10f. Zip Code		10g, Citizen o	of What Country?
	with th	eral	16732A Annandale R	oad	21727		USA	
	eath v	Funeral		Decedent Ever in U.S. 13 and Forces?	. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Specify)	Yes or No- 14. R	Race - American Indian,
99	fter d , or i amin	ğ	1 Never Married 2 Married 1	Ves 2 No	1 Yes 2 XNo			Black, White, etc.
Ö	ours a	Completed	3 ☐ Widowed 4 ☐ Divorced Year 15. Decedent's Education		edent's Usual Occupation			White f Business/Industry
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D	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)		18		rst, Middle, Maiden Surna	ame)
yla	uld be Ment narke	욘	John Ott, Sr.			Ida Mill		
Mar	shou h and 7 is n traum		19a. Informant's Name/Relationship (Type, Print				ute Number, City or Towr	
e,	and and Healt		Doris Ott - wife 20a. Method of Disposition	20b Place of Dist	nosition (Name of	Date	20c Locatio	on - City or Town, State
nor	age 1 ant of it: If it y or o		1 X Burial 2 ☐ Cremation 3 ☐ Remova	al from State New St.	Joseph s	Cem. 1/9	9/20 1 2 Emm	mitsburg,MD
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee			-		v Funeral Home
ñ	Depar Impor any ir						mmitsburg	
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death. Do not en	nter the mode of dying,	such as cardiac or res	spiratory arrest,	Approximate Interval Between
, ACT .	hysician/			SPPNC S/to	2/6			Onset and Death
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		er	Sequentially list conditions, b.	tue to (or as a consequence of):	-DIAC /N	MACTION	V	
	red Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	PENA FA Due to (or as a consequence of):	TURE			
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9 X	th cer ttendi or use	ian/	23b. Was decedent pregnant		☐ Ectopic pregnancy ☐ Other (specify)			Date of delivery Month Day Year
ĕ	e dea the a	ysic		Unknown				
Ö.	hat th ed by detac	y Ph	Part II. Other significant conditions contribution	ng to death but not resulting in the	e underlying cause giver	n in Part I.	23e. Did tobacco use co	ontribute to the cause of death?
s,	uires t n sign	q pe	PREUMONIA				1 ☐ Yes 2 ☐ N	lo 3 🗆 Probably 4 🗹 Unknown
Division of Vital Records, P.O.	iw requ	Completed by	CLOSTRIDIUM	DIFFICILE	COLITIS		24a. Was an autopsy	b. Were autopsy findings available prior to completion of cause of
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٥	Attending Potential Affer to the funeral to the funeral Affer the funeral to the	Certificate:	1 ☑ Natural 5 ☐ Pending	Date of injury 28b. Time (Month, Day, Year) injury	work?	es 2 \square No	. Describe how injury occ	curred
Siol	deatl deatl ctor: y the	ıţį.	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	. Place of Injury - At home, farm,				mber or Rural Route Number,
Σ̈́	al or A s after I Dire		4 Homicide determined	building, etc. (Specify)			City or Town, State)	
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: T	the best of my knowledge, deat	h occurred at the time, o	date and place, and d	due to the cause(s) and m	nanner as stated. I due to the cause(s) and manner stated.
	the H hin 24 the Fi nplete	Me	only one) 3 Certifying Nurse Pract	itioner: To the best of my knowled	ge, death occurred at the	time, date and place,	and due to the cause(s) ar	nd manner as stated.
	No No		29b. Signature and title of certifier		29c. License r		29d. Date sig	gned (Month, Day, Year)
J	WILT		Myorit		100 60	7000	10	11/2
	110		30. Name and address of person who complete	ed cause of death (Item 23a) (Type		GAL CAMP	our 20	HITHORSTON My
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		AT AUTO	7	
	Registr		JAN 0 9 2012	Deneva D.	park			

12-00276 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ronny Odom, II State of Maryland / Department of Health and Mental Hygiene 1- For State 2012 02763 Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner Ronny Month Day January 10, 2012 Odom, II 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2306 Brooks Drive Suitland 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Director 177-72-6541 Months Davs Hours 1X M 21 SEP 24, 1990 Usual Residence of Decedent 10b. County 10c. City, Town or Location or 28a-f show MD Prince George's is marked other than "natural", or items 23a or 28a-f sho itic event, the Medical Examiner must be notified at once. Suitland Director 10e. Street and Number 10f. Zip Code 2306 Brooks Drive, #103 20746 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 200 3 Widowed if Yes, Give Year or Dates: Present ⋧ 1 Yes 2 X No specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h
ment of Health and Mental Hygiene
taut: If item 27 is marked other than "n
or other traumatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Infantry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ronny Odom, I Cherve 19a. Informant's Name/Relationship (Type, Print) ဥ Smith/ Grandmother 527 State Street, Pottstown, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 X Burial 2 Cremation 3 X Removal from State crematory or other place) Donation 5 Other Specify Highland Memorial Pk. 01/19/2012 21. Signature of Funeral Service Licensee M00956 Physician failure. List only one cause on each line /Medical Immediate Cause (Final disease a Contact Gunshot Wound of Head ≟xamineı or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and the burial - trans Physician/Medical UNPENDED AMENDED Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth past 12 months? Fetal death 3 Ectopic pregnancy Month Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown the Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ <u>á</u> σ. 24a. Was an autopsy performed'

Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Country) PA 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. **Black** 16b. Kind of Business/Industry U.S. Marine Corps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PA 19464 20c. Location - City or Town, State Pottstown, PA 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a.
7 Park Avenue, Gaithersburg, MD 20877 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and Death The law requires that the death certificate be executed 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death Division of Vital 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes After 27. Manner of Death 28a. Date of Injury FOUND: Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural within 24 hours after death To the Funeral Director: FOUND: Subject shot self Pending the 1 Yes 2 V No 2 Accident Jan 10, 2012 Investigation 0855 hrs filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 2306 Brooks Drive #103, Suitland, MD determined Homicide (Specify) Multi-Family Apt. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 9+1 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2012 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day State Registrar's Signa Registrar

0921 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02764

			Registrar			Cei	lilicate of	Dealli			Reg. No. 🛶 🕓	/ b from	0 - 10 -
	Dhusisi	- / I	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia Medic	al .	PATRICIA		PARKER						15,20	12	8:31А м
	Examin	er	4a. Facility Name (if not institution, FREDERICK MEM				4b. City, Town, FRED	or Location ERICK	of Death		4c. County FRED	of Death ERICK	
*	Funeral			6. Sex 7	'. Age (In yrs. la	st birthday)	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birtl	n (Year)	9. Birthp Count	lace (State or Foreign
	Director	Ų	219-54-2245	1 □ M 2 🕱 F	59	Yrs.	Montale Day	1100.0			1, 1951	_	· ·
	nd now	L.	Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Lo	cation					10	0d. Inside City Limits
	ırylan a-f sh ied a	양		1-		Freder							1 X Yes 2 □ No
	or 28% notif		Maryland Fred 10e. Street and Number	erick		rreder	10f. Zip Code				10g. Citizen of	What Coun	try?
	vith th	iral	1421 Taney Aven	ue. Ant. 6	15		2170)2			United	d Sta	tes
	eath v	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S	3. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori	igin? (Spe	cify Yes or No-		ce - America	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show as marked other than "natural" or items 26a or 28a-f show a	by	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Force ied 1 Yes If Yes, Give Year or Dat	2 🗷 No		1 ☐ Yes 2 🛣			nican, etc.;		ck, White, 6	
2-0 2-0	hour "natu dical	plet		nt's Education st grade completed)	17	16a. Dece	dent's Usual Occ kind of work don	upation e during mos	at of worki	na	16b. Kind of E	Jusiness/Inc	dustry
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2	d with	a l	12 17. Father's Name (First, Middle, L	noth		Swit	<u>chboard</u>			e (First, Middle,			cacions
anc	ntal Hyged oth	2	William Boone	.ast)					e Mye	, ,	vialueri Surnam	<i>c)</i>	
Ž	12 should be file alth and Mental I 27 is marked o r traumatic eve		19a. Informant's Name/Relationsl	nip (Type, Print)		T 19h Maili	ng Address (Stree		<u> </u>		. City or Town.	State. Zip C	Code)
S	12 shulth ar 27 is r trau		Gary Parker /			1	Picnic						
<u>a</u>	1 and of Hea item othe		20a. Method of Disposition			lace of Dispo	osition (Name of matory or other p		Jan.		20c. Location		
E	Page nent c int: If		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S				Cremate	ory	2012	2,	Freder	ick, J	Maryland
Baltimore,	permit. Page 1 and 2 should be f Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Secoce L	icensee		P.	2. Name and Add	ress of Facili	ra1	Services	s. Skko	t Cod	v P.A.
<u> </u>	P a m a		1/19] 9	501 Cat	octin	Moun	tain Hw	y. Fred	erick	, MD 21701_
			23a. Part 1. Enter the disease, or shock, or beart failure, List of	complications that cannot one cause on each	aused the deatl th line.	h. Do not ent	er the mode of d	/ing, such as	cardiac o	or respiratory are	est,		Approximate Interval Between Onset and Death
- 1	nysician/	8 7	Immediate Cause (Final disease or condition	_ a. V €	entric	mlas	tach	care	Sile				Onset and Death
-	Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):	ente	MI					
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	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	P	nenn	noni	a						
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68760	tificat ng ph as th	Med	IF FEMALE:	1							T		
		ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	Birth 2 🗌 Feta	al death 3	Ectopic pregn	ancy				ate of deliver	ery Day Year
P.O. Box	requires that the death obeen signed by the attershould be detached for its	by Physicia	1 ☐ Yes 2 📉 No 9 ☐ Unknown	9 Unkn	ant at time of o	death 51	Other (specify)						
Ö.	nat th	유	Part II. Other significant condition	ons contributing to de	ath but not res	sulting in the	underlying cause	given in Parl	t 1.	23e. Did to	obacco use con	tribute to th	ne cause of death?
s,	ires t sign Id be	q p		_						1 🗆	Yes 2 No	3 Prof	bably 4 🗌 Unknown
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ec	ne lav e has age 2	mo								autor perfo	rmed?	death?	·
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oŧ	ng Ph fter th ineral		27. Manner of Death 1 ↑ Natural 5 □ Pendir	28a. Date o		28b. Time o injury	f 28c. Ir	ork?	_	28d. Describe h	now injury occur	red	
ion	tendi leath. or: A the fu	iji	2 Accident Investi	gation not be				Yes 2 L	_l No				10 1 11 11
Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for completely filled in by the funeral director, page 2.	Certificate:	4 ☐ Homicide determ	ined 28e. Place	of Injury - At ho ig, etc. (Specif)		reet, factory, offic	e		City or Tov		er or Hural	l Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled		29a, Certifier 1 Certifying	Physician: To the be	est of my know	ledge, death	occurred at the t	ime, date an	d place, a	nd due to the c	ause(s) and mar	ner as stat	ed.
	ne Hc in 24 l	Medical	(Check 2 Medical I only one) 3 Certifying	Examiner: On the basi Nurse Practitioner:	s of examinatio To the best of r	n and/or inve my knowledge	stigation, in my op e, death occurred	inion, death o at the time, d	ate and pl	t the time, date a ace, and due to t	and place, and d the cause(s) and	manner as	use(s) and manner stated. stated.
	Vithi Vom		29b. Signature and title of certifie	/.) A	/.		29c. Lice	nse number			29d. Date sign	ed (Month,	Day, Year)
			1 my	/ xue / l	m		WDI	3510	06		1/15	12	0/0-
	^-		30. Name and address of person	who completed caus	e of death (Item	n 23a) (Ty pe ,	Print)			0.0	_		0

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 9:00 AM Olivia Jody Pinto January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 9693 Royal Crest Circle Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 054-50-0781 1 M 2 XF 56 Yrs May 4, 1955 New York 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Frederick Maryland Frederick 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 23a Funeral 21704 USA 9693 Royal Crest Circle items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Medical other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nancy Cosentino Raymond DellAngelo of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21704 9693 Royal Crest Circle, Frederick, Maryland Raul Pinto - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State i oi <u>f</u> i 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department Important: If any injury or 1-17-2012 4 Donation 5 Other (Specify) Frederick, Maryland Stauffer Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home panule 1621 Opossumtown Pike, Frederick, Maryland 21704 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 1/2 yrs Immediate Cause (Final Physician/ a Metastatic Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 as the l IF FEMALE asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 1 Yes 2 p signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, should b 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has director, page 2 autopsy perform After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certific 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 L only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D0061083 January 16, 2012 MO

Registrar

 O_f

State

Paul Thambi

31. Date filed (Month, Day, Year)

ack

6420 Rockledge Dtive, Suite 4200, Bethesda, Maryland

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

	I	me	nded Item 18 per F.	Type or Print in H. 01/12/12 State of Maryla	Black Ir Carrol and / Depa	delible Inl 1 County , artment of F	k. Ensure A Will Tealth and N	III Copies Ilental Hygi	Are Legi iene	ble.	
	Physicia	n/	State Registrar 1. Decedent's Name (First, Middle, Last) Barbara Eileen Po			tificate of L			eg. No. 2	112	3. Time of Death 12:38 AM
	Medic Examin		4a. Facility Name (if not institution, give str	reet and number)		4b. City, Town, or Westmir	r Location of Death	1000000	4c. County c		ounty
le.	Funeral Director		211 30 0073	7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	g. Birthpl Counti Maryl	lace (State or Foreign ry) and
	aryland a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll (City, Town or Loc neytown	cation				10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 4174 Francis Scot	t Key Highw	ay	10f. Zip Code 21787	'	Į.	og. Citizen of W Jnited S	hat Count tate	try?
036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	Was Decedent Ever in Armed Forces? □ Yes 2 X No If Yes, Give Year or Dates.	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, e wh	
21215-0036	e filed within 72 hours after death with the Maryland ttal Hygiene. So or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12) 12	cation e completed) College (1-4 or 5+)	(Give	O NOT use retired)	during most of work	ing	16b. Kind of Bus		ustry
Maryland	2 should be filed within the and Mental Hygiene. 27 is marked other the traumatic event, the N	To Be	17. Father's Name (First, Middle, Last) George W. Baker				Mildred	e (First, Middle, M. L. Baker	Mild:	red I	. Schultz
			19a. Informant's Name/Relationship (Type Patricia Ann Cul	lison/siste	r 42 Wi	ndfield		utztown,	PA 195	30	
Baltimore,	1011		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ampstead	d Cemeter	y Jan	2012		ead,	Maryland
Ball	permit. Page Department Important: I any injury o			MO MO	1072 9		Main Str		pstead,		land 21074
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09	cate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
Box 68760	tth certifications at the second seco	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live Birth 2 3 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Dat Mor	e of delive	ery Day Year
ls, P.O.	uires that the dea n signed by the a uld be detached (by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	underlying cause gi	iven in Part I.				ne cause of death? Dably 4 Unknown
Records,	The law require cate has been si page 2 should I	Completed			-			24a. Was a autops perfori 1 □ Yes	med? p	Vere autoporior to colleath?	psy findings available mpletion of cause of 2 No
Vital	hystcian: The nis certificate I director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1	□ ER/Outpatie	Oth	Place of Death (Chec ner: 4 \(\sum \) Nursing H	ck only one) ome 5 🗆 Reside	ence 6 0the	er (Specify	Dore
ion of	eath. or: After thi the funeral	ificate:	27. Manner of Death 1	28a. Date of injury (Month, Day, Year		M 1		28d. Describe ho			Hous
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)			28f. Location (St City or Town	n, State)		
	the Hosp hin 24 hor the Fune npleted fi	Medic	(Check 2 Medical Examinonly one) 3 Certifying Nurse	cian: To the best of my kr er: On the basis of examin Practioner: To the best of	ation and/or inves	stigation, in my opini death occurred at th	ion, death occurred a he time, date and pla	at the time, date an ace, and due to the	nd place, and due cause(s) and ma	to the cau	use(s) and manner stated ated.
	M71		29b. Signature and title of certifier	A00		29c. Licens	007	1746	29d. Date signed	(()) Z
	10		DRJ. Line	empleted cause of death (5 Cen	ter St	- Westr	ninste	RIM	121	157
	Sta		31. Date filed (Month, Day, Year)	32. Rygistrar's Si	gnature	booker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1815 P 07-16-2012 Physician/ Gabriel Santiago Perdomo Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Harford Havre de Grace 208 Decoy Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday) Funeral 212-46-8434 Director 1 🛛 M 2 🗆 F 81 Colombia 02-04-1930 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Havre de Grace 1 X Yes 2 ☐ No Maryland Harkord 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 5 Funeral United States of America items 23a 208 Decoy Drive 21078 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ♥ Yes 2 □ No Specify: Colombian Specify: Hispanic 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Health Care Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amada Aldana Luis Perdomo .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gladys Perdomo (wife) 208 Decoy Drive. Havre de Grace, Maryland 21078 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o RA Ferrus & Co. Inc. 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State 01-17-2012 West Chester, Pennsylvani 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zelman Funeral Home Signature of Funeral Service Livins 123 South Washington Street, Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a conseduence of, attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a detached f g Unknown a Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed Yes 2 1 ☐ Yes 2 ☐ No safter death.

Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Certificate: To Be examiner? Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havre de Grace MD Benjamin Revoluti

State Registrar aistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Kitty Yin Pomeroy 10:10 p ^M 2012 January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Hospice Casey House Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 214-70-0761 1 □ M 2X F 54 Mar 16, 1957 Hong Kong Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2X No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 USA 8207 Queen Annes Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Microbiologist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Sun-Shui Ma Lee

8207 Queen Annes Drive Silver Spring, MD 20910

Date

Jan.

16,

20c. Location - City or Town, State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show be notified at

Director

Funeral

Completed by

Be

ည

Gim Loon Lee

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

31. Date filed (Month Day, Year) 2012

Roger Pomeroy / Husband

1 Burial 2 Cremation 3 Removal from State

tending physician for use as the buria the ed by the within 24 hours after death.

To the Funeral Director: After of properties of the funer of the function of the funer of th

Division of Vital Records, P.O. Box 68760

	4 Donation 5 Other (Specify)	Metro	politan C	rematory	2012	Alexar	ndria,	Virginia	
	21. Signature of Funeral Service License	1000	Francis 500 Uni	d Address of Facility Lollins versity Blvd	Funeral . W., S	Home 11ver	Inc. Sprin	g, MD 20901	ļ
	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	not enter the mod					Approximate Interval Between Onset and Death	
Ì	disease or condition resulting in death)	Leiomyosarcoma Due to (or as a consequence							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfuling Cause (Disease or injury	Due to (or as a consequence	e of):						
	that initiated events resulting in death) Last	Due to (or as a consequence	e of):						
edi		1							-
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1				23	d. Date of de Month	elivery Day Year	7
ed by Pn	Part II. Other significant conditions con	ntributing to death but not resulting	g in the underlying	cause given in Part I.				o the cause of death? Probably 4 ^X Unknown	ı
complete							prior to death?	utopsy findings available completion of cause of	
Re	25. Was case referred to medical examiner?			26. Place of Death (Chec					
0	1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 🗆 D	OA Other: 4 \(\sum \) Nursing H	ome 5 🗆 Resi	dence 6 X	Hospic	G.P	
Certificate:	27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	Time of 2 injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factor	y, office	28f. Location (City or To		lumber or Ru	ıral Route Number,	
Medical	(Check 2 Medical Examin	ician: To the best of my knowledge ner: On the basis of examination and e Practitioner: To the best of my kn	or investigation, in	my opinion, death occurred a	at the time, date	and place, at	nd due to the	cause(s) and manner state	∍d.
	29b. Signature and title of certifier		290	c. License number			signed (Mont		
		0		D37142		Jan.	16, 2	2012	

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Registrar

15

State

faces

30. Name and address of Aerson who completed cause of death (Item 23a) (Type, Print)
G. Coleman, MD 1355 Piccard Drive, #100, Rockville, MD 20850

12-00335 Dung Hoang Phan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oung Hoang Pha		State of Maryland / L - For State legistrar	Certificate of D			g. No. 201	2 0276
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle,Last) Dung Hoang Phan			2. Date of Death Month January 11	Day Year	3. Time of Death 2252 hrs
· 1		4a. Facility Name (if not institution, give street and number)		City, Town, or Location of		4c. County of Death	
Funeral		Outerloop 495 - under 270 overpass 5. Social Security Number 6. Sex 7. Age (Ir		Bethesda If Under 1 Year If Under 1	24Hrs. 8. Date of Birt	Montgomery h(MM/DD/YYYY) 9. Birt	hplace (State or
Director		227-69-5359 _{1\(\text{M}\)M 2\(\text{F}\)}	_	Months Days Hours	Min. 08/08	/1968 Foreign Cou	n Vietnam
any	f	,	c. City, Town or Location				10d. Inside City Limits
e Maryland or 28a-f show led at once.	횴	VA Loudoun	Sterling	Of. Zip Code		g. Citizen of What Cour	1 Yes 2 X No
death with the Maryland or items 23a or 28a-f sho must be notifited at once.	Il Director	22895 Adelphi Terrace		20166		USA	
	y Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Every Armed Forces? 1 Yes 2 Married 17 Pastes:	If Yes,	ecedent of Hispanic Origin specify Cuban, Mexican, Fees 2 X No specify:	Puerto Rican, etc.)	White, etc.	
hours a natura	ed by	15. Decedent's Education (Specify only highest grade comple		Usual Occupation (Give king of working life, DO NOT use		16b. Kind of Business/li Baltimore	•
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examine:	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Mecha	anic		Auto Expe	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Cor	17. Father's Name (First, Middle, Last) Nghia Phan			Name (First, Middle, M -Dung Huy		-
212 hould be and Ment is mark	임	19a. Informant's Name/Relationship (Type, Print) Vui Tran-Wife		ddress (Street and Numb			
e, MI and 2 s Health a item 27	ŀ	20a. Method of Disposition	20b. Place of Dispositio		Date	20c. Location - City or	Town, State
Pages lant of Jant: If		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	I Park		Jan. 21, 2012	raillax,	
Baltimore, MD 21215 permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, th		21. Signature of Funeral Service Licensee	22. Nam Hom	ne and Address of Facility e,9902 Bra	Fairfax ddock Rd.	Memorial ,Fairfax,	Funeral VA 22032
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter the	mode of dying, such as car	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Ir			-		Death
	<u></u>	Sequentially list conditions, if any, leading to immediate b	ence of):				
0	Examine	cause. Enter Underlying Cause (Unsease on injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	ence of):				
60, ate be executed hysician and	E E	d					
60, ate be ex hysician e burial		UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of	of pregnancy			23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/	3b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at tim 1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal	death 3 Ectopic p	pregnancy	Month D	Day Year
that the d	by Ph	Part II. Other significant conditions contributing to death but	ut not resulting in the und	lerlying cause given in Part		bacco use contribute to	
ords, P	eted t				24a. Was a	an 24b. Were au	topsy findings available completion of cause of
(ecor he law i ate has b age 2 sh	Completed		-		autop perfor 1 ✓ Yes	med? death?	
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient	2 ER/Outpatient 3	26.Place of Death (C		Residence 6 🗸 Other	- Scene
Division of Vital Records, P.O. ral or attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	2 2	27. Manner of Death 28a. Date of Injury (Mooth, Day, Year)	28b. Time of Inju	ry 28c. Injury at Work?	28d. Describe t	now injury occurred	. 000.10
ivision or Attendi after death. Director:	catio	2 Accident Investigation 28e Place of Injury		1 Yes 2 ✔ I factory, office building, etc.	No	Street and Number or Ru	ıral Route Number, City
Divi	Certification:	3 Suicide Could not be determined (Specify) Major	r Road / Highway		or Town, S Outerloop 495	- under 270 overpas	
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After I completely filled in by the funeral	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner					
10 To To To	Mec	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
/		30. Name and address of person who completed cause of deal	th (Item 23a)	O.C.M.E.		January 12, 2012	
		Ana Rubio MD. Assistant Medical Examin	ner 900 W. Baltím		e, MD 21223		
S Regis	tate	31. Date filed (Month, Day, Year). 32. Registrar's	Signature back	J.			

				Please					k. Ensure			0	
		-	For State Registrar		State	of Marylan		rtment of l	Health and Death	Mental Hy	giene Reg. No.	2012	02770
F	Physicia Medic		1. Decedent's Name Violet	Full		Peirce				2. Date of De Month Janua	eath Bry Day	7, 2012	3. Time of Death 10:45 am
	Examin		4a. Facility Name (if	not institution, give		mber)			or Location of Death	n		County of Death	
I	uneral		5. Social Security Nu	ımber 6. S		7. Age (In yrs. la	ast birthday)	If Under 1 Year					nplace (State or Foreign
	irector		404-24-04		□ M 2 🏲 F	92	Yrs.	Months Days	Hours Min.	(Month, Da			ntry)
pur	show	o	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Loc	ation		nug. 7	, 1)1	J KI	10d. Inside City Limits
Maryl	28a-f	Funeral Director	MD	Montg	omery	В	rookev	ille					1 🗌 Yes 2 🏿 No
th the	Sa or S	al Di	10e. Street and Num				-	10f. Zip Code				izen of What Cou	untry?
ath wit	ms 20 must	nner		own Farm	1	edent Ever in U.S	112 14	20833		pooify Voc or No		ISA	· · · · Indian
after dea	Department or heath and inventing Hyglene. Importment of heath and inventing their unatural,", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status1 ☐ Never Marri3 ☒ Widowed	ed 2 Married	Armed For 1 Yes If Yes, Gi	orces? 2 No ve		Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	o Rican, etc.)		14. Race - Amer Black, White Specify: Wh1	, etc.
hours	natura lical E	Completed		15. Decedent's E				ent's Usual Occup				ind of Business/I	
in 72	han "ı e Med	duo	(Spec	ndary (0-12)	ade completed College (life. DC	NOT use retired,	during most of wor)	rking			,
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be file	rked o	10		. Fuller					18. Mother's Nar		, Maiden S	Surname)	
hould	snd M s mar lumat		19a. Informant's Na	me/Relationship (7	ype, Print)		19b. Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zip	Code)
nd 2 s	m 27 in tra		Steven J.		Son		19701	Golden	Valley La	ane, Bro	okev	ille, M	D 20833
ge 1 a	if ite			Cremation 3		n State C		atory or other pla		an. 18		ocation - City or	
it. Pa	artmer ortant injury		4 ☐ Donation 21. Signature of Fur	5 Other (Speci		Par		emorial		2012		ville,	MD
perm	any any once		M	Hec my			F:	rancis J 00 Unive	ersity Bl	s Funera vd. W	al Ho Silv	me Inc. er Spri	ng,MD 20901
			23a. Part 1. Enter the	ne disease, or com t failure. List only o	cations that	caused the death			ng, such as cardiac				Approximate Interval Between
	sician/		Immediate Cause (I disease or conditio	Final		estive H	eart F	ailure					Onset and Death
	/ledical aminer		resulting in death)			(or as a consequ	,	_					
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exec	⊏ '@	ш	resulting in death) L		Due to	(or as a consequ	ience of):						
ate be	chysic the bu	dice			d								
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leath o	e atter	sicia	in the past 12 r	nonths?	4 Pre	Birth 2 Feta gnant at time of c	ldeath 3 L death 5 L	Ectopic pregnar Other (specify) _	ncy			Month	Day Year
t the c	igned by the atte be detached for	Phys	9 Unknown		9 📙 Unk		102 - 2 - M		· · · · · · · · · · · · ·	1			
es tha	igned I be de	l by	Part II. Other signif	cant conditions of	ontributing to	death but not res	ulting in the ur	iderlying cause g	iven in Part I.				the cause of death?
requir	been sig	etec	-							24a. Was			opsy findings available
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an: T	certificate has t lirector, page 2 s	Be C	25. Was case referre	ed to medical				26. F	Place of Death (Che		2 🗗 No		2 No
hysici	this certific ral director,	To E	examiner?		Hospital:	Inpatient 2	ER/Outpatien	3 DOA Ott	her: 4 Nursing H	lome 5 ☐ Res	idence 6	ASSIST Other (Speci	ed Living
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Attend	ctor.	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigatio 6 Could not be determined	e 280 Plan	e of Injury - At ho	me, farm, stre		Yes 2 No	28f. Location	(Street and	d Number or Run	al Route Number,
tal or	eral Direct		4 LI HUMICIDE	determined	build	ling, etc. (Specify)			City or To			
the Hospital or Attending Physician: The law requires that the death	Funera etely fill	Medical	(Check 2	Medical Exam	i ner : On the ba	isls of examination	n and/or investi	gation, in my opin		at the time, date	and place	, and due to the o	ause(s) and manner state
To the	To the Fun completely	Σ	only one) 3 29b. Signature and	-	se Fractitione	n. 10 the best of h	ny knowledge,	29c. Licens	the time, date and p se number	Jiace, and due to		e(s) and manner as te signed (Month	
	12		\	1) / / ()			D.	58962		T a=	. 0 20	1.2

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) **JAN 17 2012**

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shashank Patel, MD 18121 Georgia Avenue, #102-103, Olney, MD 20832

D58962

Jan. 9, 2012

12-0066	6			
William	J	Phillips.	Ш	

/illiam J Phillips, I		State of Maryland / Depar	tment of		nd Menta	l Hygie		20	12 0277		
Physician	_	egistrar . Decedent's Name (First, Middle,Last)	-				ate of Death		3. Time of Death		
Aledical Examine	,	William J. Phillips, II				Ja	onth nuary 24	Day Year , 2012	1406 hrs		
		a. Facility Name (if not institution, give street and number)	4		or Location of D	eath		4c. County of			
		104 Mariners Circle		Stevensvil				Queen Ai			
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Ye	ear If Under 2 ays Hours	****			9. Birthplace (State or Foreign		
Director		073-44-0472 1X _{M 2} F 60	Yrs.		ayo Modio	(01/11/	1952	country) New York		
P	_	Usual Residence of Decedent Oa. State 10b. County 10c. City, 1	Town or Locati	on					10d. Inside City Limits		
ow any	M		tevens						1 Yes 2 X No		
Maryland 28a-f show d at once.	عِ لِـُـــُــــُــــُــــــــِةٍ عِلَيْ	aryland Queen Anne's S Oe. Street and Number	CEVEIIS	10f. Zip Code			100	g. Citizen of Wha	at Country?		
to 28a-f sh iffed at once		104 Mariners Circle		21666				USA			
_ 66 _	_	Marital Status 12. Was Decedent Ever in U.S.			Hispanic Origin				- American Indian, Black,		
r death with or items 2: must be a		1 Never Married 2 Married Armed Forces?	lf Y	es, specify Cub	an, Mexican, Po	uerto Ricar	n, etc.)	White,	etc.		
s after d		Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X	lo specify:			Specify:	White		
5-0036 led victin 72 hours afte Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed)			oation (Give kind fe. DO NOT us		ione	16b. Kind of Bus	iness/Industry		
6 n 72 h		Elementary/Secondary (0-12) College (1-4 or 5+)				,		Hamlan.	Davidson		
5-0036 led within 72 hour Hygiene. other than "natu	[]-	12th 7. Father's Name (First, Middle, Last)	Manag	ger	18 Mother's N	Name (Firs	t Middle M	aiden Surname)	-Davidson		
215- 215- be filed atal Hyg ent, the		William J. Phillips, Sr.					ine M				
21215-0036 ould be filed within 7 a Mental Hygiene. # marked other than it event, the Medical Commit		a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.									
Baltimore, MD 21215- permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the	1	Pamela R. Phillips/ Wife	104 1	Mariner	s Circl	e, St	evens		4D 21666		
Healt Fitem		T	lace of Dispos ematory or oth	ition (Name of one place)		Dat		20c. Location - 6	City or Town, State		
TOOF Pages ent of nt: Ib			las Cr	ematory		1/26/			ter, Maryland		
altir mit. P partm porta	1	1. Signature of Funeral Gentles Licensee							Funeral Home		
E E E E		Ilmill laler-							er, MD 21037		
Physician	7	3a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	Do not enter the	ne mode of dyin	ig, such as card	liac or resp	oiratory arre	st, shock, or hear	Between Onset and		
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certificate anding physise as the b		3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of dea	~ 	tal doutil	3Ectopic p	regnancy		Month	Day Year		
Box 68760 death certificate b the attending physical for use as the bu	Frigicianime	1 Yes 2 No 9 Unknown	^{atn} 5 Ot	her (Specify)							
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Division of Vital Records, pital or Attending Physician: The law require ours after death. eral Director: After this certificate has been sifiled in by the funeral director, page 2 should the constitution of the funeral director.	0	1 Yes 2 No	ER/Outpatient		Other ₄ N			Residence 6			
ing Pi		(Month, Day, Year)	28b. Time of I		njury at Work?	h1	Describe h	ow injury occurre working	on running		
Sion Attend death. ctor: y the f		2 X Accident Investigation fd 1-24-12	fd 2:0	0 pm	Yes 2X N	" vel	hicle	in enclo	sed garage		
ivision I or Atten after deat The Director: d in by the	Certification:	3 Suicide 6 Could not be determined (Specify)			_		or Town, St	ate) 104 Ma	azines Circle.		
hou bou		4 Homicide Garage		sidence				ville,Md			
To the Howithin 24 h	100	(Check only one) 2 Medical Examiner: On the basis of examination ar	je, death occu nd/or investiga	tion, in my opini	ion, death occu	rred at the	time, date a	and place, and du	ue to the cause(s)		
To To Com	₽	and manner stated. 29b. Signature and title of certifier			ense number				ed (Month, Day, Year)		
		Adla Brand MA		0.0	C.M.E.			January 25,	, 2012		
	ŀ	30. Name and address of person who completed cause of death (Item	23a)	1		-					
8		Melissa Brassell, MD Assistant Medical Examin		/. Baltimore	Street, Bal	timore, l	MD 2122	3			
Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	re								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Sarah Beth Redmer Rupp 4:05 2012 January Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death
Carroll County **Examiner** Taneytown 2810 Baumgardner Road If Under 1 Year If Under 24 Hrs. 5, Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours 217-13-8946 **Director** 1 🗆 M 2 🔀 F 30 2/25/1981 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State at Director notified Carroll Taneytown MD 28a-f 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò "natural", or items 23a o Funeral USA 21787 2810 Baumgardner Road death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No white Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates intal Hygiene. sed other than "natura c event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed within thent of Health and Mental Hygiene rtant; If item 27 is marked other th njury or other traumatic event, the special needs teacher education 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Suzanne Cooke 2 Bruce W. Redmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2810 Baumgardner Road, Taneytown, MD 21787 Luke M. Rupp, husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Hampstead, MD 1/13/2012 Hampstead Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 X Main Street, Hampstead, Semmer 934 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Metast Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exam ending physician and use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Yes been signed by the a should be detached 9 | Ilnknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 10 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 1 Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director A completely filled it by that 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one DIRECTOR, 29c. License number 29d. Date signed (Month, Day, Year) 9 023675 WIL www MEDICALONCOLOGY

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PSSC. DINEHOWER, W.S. TUKENS Hapking Common Print)

JAN 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OMP - 18 - 20 72 04:15 AM Janice Ida Rector Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Havre de Grace Harford 427 Webb Lane Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 215-30-3862 1 □ M 2 🂢 F **Director** 78 11-16-1933 Maryland Usual Residence of Deceder 28a-f shov 10d. Inside City Limits 10c. City. Town or Location Medical Examiner must be notified at Funeral Director MaryLand Harford Havre de Grace 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 427 Webb Lane 21078 United States of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11 Marital Status Armed Force Completed by 1 Never Married 2 Married "natural", or 2 X No | コカンリオルタ 13,2012 | Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Supermarket Meat Wrapper the Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Howard Morrus ဂ Elsic Wilkinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,25403$ 19a. Informant's Name/Relationship (Type, Print) 77 Jeb Stuart Lane Martinsburg, West Virginia Howard Oals (son) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 01/21/2012 Havre de Grace MaryLand 4 ☐ Donation 5 ☐ Other (Specify) Rock Run Cemetern 22. Name and Address of Facility Zellman Funeral Home P A るつ 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death sate has been signed by the a page 2 should be detached to Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 🗌 No the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one 2 No Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Medical Certificate: Natural Accident injury 5 Pending 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Configure Nurse Cractificner To the control my move and at the time, date and place, and to the cause(s) and manner stated. (Check

State Registrar 29b. Signature and title o

of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician/ Myer Rosenfeld Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** ent gomer 8. Date of Birth (Month, Day, Year) 1 Year If Unde **Funeral** Pennsylvania 579-10 10/28/1914 Director 97 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f show 10a. State ä **Funeral Director** the Maryland 1 Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st important: If item 27 is marked other than "natural", or items 25a or 28a-f st important: If item 27 is marked other than "natural", or items 25a or 28a-f st important: If item 27 is marked other than "natural", or items 25a or 28a-f st important in the Medical Examiner must be notified and once. Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20906 3005 S. Leisure World Blvd., Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Completed by 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify. White 21215-0036 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland Katie Spector မ Louis Rosenfeld 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4302 Dahill Place, Alexandria, Virginia 22312 Beverly E. Polmar - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Lebanon Cemetery 01/15/2012 Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Euneral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final name _Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial tracei and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month in the past 12 months? for Pregnant at time of death 2 No ed by the a detached 1 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific graphetely filled in by the funeral director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 110 은 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work? Natural 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide
4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) Signature and title of certifie

Registrar

Prince Phi

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O1 Day 2012 Robbins ρМ 2:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home Rockville Montgomery 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🖾 F Davs Hours Min. (Month, Day Director 057-16-4920 95 10/17/1916 New York Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Montrose Ave 20852 U.S.A. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian any injury or other traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Adler Becky Aronowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Robbins - Son 11146 Black Forest Way Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David 01/15/2012 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01163 National Funeral Home 7482 Lee Highway Falls Church,VA 22042 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ estive disease or condition Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, Due to (or ae a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician Medical that the death certificate be 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law has page 2 autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Division of Vital Be 26. Place of Death (Check only one) Hospital · this / ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 🗆 No hours after death neral Director: A Accident
Suicide Investigation eted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. En	nsure All Copies Are Legible.
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			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate of	Death	2	Re Date of Death	g. No.	012	3. Time of Death	
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$\dot{\boldsymbol{x}}_{i_1}$	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town,	or Location o		ander y		ty of Death	3130 11	
أميد			Shady Grove Adv	entist Hos	spital		Rockvil	1e			Montgomery			
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days			Date of Birth (Month, Day,	(ear)	9. Birthp Count	lace (State or Foreign rv)	
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	or 28 e not		10e. Street and Number				10f. Zip Code			10	ng. Citizen of	What Coun	try?	
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	items items	핊	11. Marital Status	12. Was Decede			Vas Decedent of Yes, specify Cub					ace - America ack, White, e		
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Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationshi			1	g Address (Stree							
6	and 2 lealth		Monica Rivero, 20a. Method of Disposition	Daughter	1001 5			Bridge					and 20852	
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	ate be executed physician and the burial traget	dical E	resulting in death) Last	Due 10 (0)	as a consequ	ionec oi).								
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89	ding se as	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. [Date of delive	erv	
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cor	aw reas be	Completed								24a. Was an autopsy	/	prior to col	osy findings available mpletion of cause of	
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Division of Vital Records,	al or a after t Direction to the second to t		4 - Homicide determine	building	g, etc. (Specify)			- 1	City or Town,	State)			
tund	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transitions.	Medical		Physician: To the besis									ed. use(s) and manner stated.	
	the H hin 24 the Fu	Mec	only one) 3 Certifying	Nurse Practitioner:			death occurred a	t the time, da		and due to the	cause(s) and	manner as s	stated.	
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			1 Child	1	M. D	,	900	14 750)		_ write	y 'cl	7017	
			30. Name and address of person v Quifung them		of death (Item	cdical	9 00 Center	Drive	c, Po	ckville	Mary	land	20450	
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	Registr		JAN 17 20	12 2.	gistrar's Signat	Sau	Les.							

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		_	Decedent's Name (First, Middle, Last)						ate of Death	Day Ye		3. Time of Death
k.	Physicia /Medic		Gary Fr	ederick H	Reidinger	<u> </u>		_	anuary	25, 2012	2	7:02 a M
2	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of D	Death		4c. County of D	eath	
			2749 Flintridge Dr	rive		Myersv				Frede		
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	Hours A	Min. 8. D.	ate of Birth Month, Day, Ye	9.	Birthplac Country	e (State or Foreign) ylvania
в	Director		204-46-3166		56 Yrs.			Apı	r. 12,	1955 P	enns	yivania
	pue *		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation					10d	. Inside City Limits
	laho aho	ō		.1-	Myersvi	110						1 X Yes 2 □ No
	28a-	ect	Maryland Frederic	K	Myersvi	10f. Zip Code			10g.	Citizen of What	t Country	?
	with with		2749 Flintridge Dri	lve		21773				USA		
	deeth Ta 23	Funeral Director		2. Was Decedent Ever	in U.S. 13.	Was Decedent of h	lispanic Origin	? (Specify	res or No-	14. Race - A		
(0	r Her	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Yes, specify Cub	an, Mexican, P	Риепо нісаг	1, O(C.)		Vhite, etc	
ဗ္ဗ	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:			Specify:	wnit	e
21215-0036	within 72 hours after deeth with the Maryland ene. Than "netural", or items 23e or 28e-f ahow La Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of	f working	168	o. Kind of Busine	ess/Indus	stry
2	thin en	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire				II a tra 7		
7	ygier ygier t,	Ç	12	4	Direct	or of En	,		4 Middle Mai	Hotel		
밀	be fill H d off	Be	17. Father's Name (First, Middle, Last)				Joan		s, middie, mai Gricosk			
<u>\}</u>	Men Marka Marka	욘	Claire Reidinge		401 14 6	ng Address (Street	1				to Zio C	ode)
Maryland	n and		19a. Informant's Name/Relationship (Type Beverly R. Reidin		2.749	Flintrid	ge Driv	ve, My	ersvil	le, MD	2177	3
e,	1 and teelth		20a. Method of Disposition	2	Ob. Place of Dispo	osition (Name of	- [Date		c. Location - City		
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f ahow any injury or other traumatic avant, Ita Medical Examinat must be notified at ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	Immacula	natory or other pla te Heart	of .	0.1	2012 41	1 - 4 + -		T) A
∄	it. Peritant		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of neral Service License		Mary Cem	etery 2. Name and Addre		n.31,		bottsto lain Str		rA
Ba	Depe Impo Impo any i		DA 5/1	16		icketts I		Home		ville,		1773
			23a. Part1. Enter the disease, or complic	ations that caused the		ter the mode of dyi	ng, such as ca	ardiac or res	piratory arrest	,	A	opproximate
2			shock, or heart failure. List only one	e cause on each line.	TIV 1	ANCRE	-AT:	0	anir F	P	0	Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	HNUKE	11110		411000		1	(0)(11)3
	Examiner			200 10 101 00 00 00								
	-	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	exec en an riel-tr	Exa	resulting in death) Last	Due to (or as a co	nsequence of):							
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9	ntifica ng ph as th	Jed	IF FEMALE:									
Вох	eeth certific ettending p for use as t	an/h	23b. Was decedent pregnant	3c. If yes, outcome of po 1 ☐ Live birth 2 ☐		⊒Ectopic pregnanc	·y			23d. Date o Month		y Day Year
-	he ett	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)				l l l l l l l l l l l l l l l l l l l	_	,
P.0	that the de ned by the e deteched (Phy	9 Unknown				on in Dort I		22a Did toba	co use contribu	ite to the	cause of death?
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oro	w requires to been signed should be	ted						_		-		V 1 10.121
e S	e law hes b	Completed							24a, Was an autopsy performe	prio	r to comp	sy findings available pletion of cause of
=	Page	S							1 Yes 2	No 1	Yes 2	No No
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of	Phys this al dir	၉	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatie	nt 3 DOA	4 🗀 19015	sing Home	F	ce 6 Other	, ,,	
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isi	Attanding r death. actor: After by the fune	ica	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, si				Location (Stre	et and Number	or Rural	Route Number,
Division	or A efter Dirac	Certification:	4 Homicide determined	building, etc. (5	Specify)				City or Town,	State)		
	To the Hospitel or Attandi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Cartifying Phys	ician: To the best of m	y knowledge, dea	th occurred at the t	ime, date and	I place, and	due to the cau	se(s) and mann	er as sta	ted.
	124 Fulletely	Medicai	(Check only 2 Medical Examination)	and manner stated	amination and/or in	nvestigation, in my	opinion, death	n occurred a	t the time, date	e and place, and	d due to t	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	11%		se number		290	d. Date signed (Month, D	ay, Year)
) Op	1	VI) .	DI	01961	/	J	an Ho	, 20	12
F	6.1		30. Name and address of person who co	npleted cause of death	(Item 23a) (Type	, Print)		222				
0	(O)		Sadaf Taimur, MD.			son Driv	e, Suit	te 200	, Fred	erick, N	MD 2.	1/02
	St Regist	ate	31. Date filed (Month, Day, Year) FFR 0 2 201	32 Pogistrar's	Signature	-10						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY MILDRED TAYLOR ROLLISON 2012 12:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Kent Chestertown Chestertown Nursing & Rehab If Under 1 Year If Under 24 Hrs.
Manths Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F ^{Year)}930 July 14 Pennsylvania 197-24-2167 81 Director Usual Residence of Decedent or items 23a or 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director MD Kent Rock Hall 1 X Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 6027 Lawton Ave. 21661 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11, Marital Status Armed Forces?

1 Yes 2X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural", 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Mildred Berry George Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 23559 Canvasback Rd. Chestertown, MD. 21620 item 27 i Cheryl Baker other 20c. Location - City or Town, State 20a Method of Disposition 20h Place of Disposition (Name of permit. Page 1 Department of Important: If it any injury or o o cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Wesley Chapel Cemetery 2/1/12 Rock Hall, MD. 4 Donation 5 Other (Specify) Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death THRIVE Physician/ -AILVR disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 □ Probably 4 □ Unknown been s 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 No Yes 25. Was case referred to ical 26. Place of Dea (Check only one) Be examiner? Hospital 2 🗆 No Other 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 5 Pending 1 Natural 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying parse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature ar Day, Year) 2gh D36054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D. 120 Speer Rd. Chestertown, MD. State Registrar

			_ FOI	partment of Health and N e <i>rtificate of Death</i>	ental Hygien/ Reg. ۱	0010	0 02779	
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death 01-19-20	= 0 1 2	3. Time of Death	
	Medic Examin	al	John Milion Smith 4a. Facility Name (if not institution, give street and number) Elkion Health & Rehabilitation	4b. City, Town, or Location of Death		4c. County of Death CCCL		
-	<i>)</i>			Elkion	8. Date of Birth		nplace (State or Foreign	
	Funeral Director		215/32/5940 1 ♥ M 2 □ F 75 Yrs.	Months Days Hours Min.	10/05/19	36 Mc Sey		
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location			10d. Inside City Limits	
	Maryla 28a-f otified	irect	Maryland Harford Havre de				1 🛚 Yes 2 🗆 No	
	with the 23a or ist be r	eral D	10e. Street and Number 515 Warren Sirect Api 11	10f. Zip Code 21078		Citizen of What Co. Led State	s of America	
330	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	d by Funeral Director	11. Marital Status 1	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.	
ς Σ	2 hours "natur edical (Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	cedent's Usual Occupation re kind of work done during most of work	ing 16b.	. Kind of Business I	ndustry	
12.12	within 7 giene. er than the Mo			DO NOT use retired) Driver	T)	ransporta	tion	
Baltimore, Maryland 21215-0036	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Hughes Oliver Smith	18. Mother's Nam Edna Bea	e (First, Middle, Maide UUUCE DEBO	en Surname) UUGh		
, Mar	nd 2 shoul salth and I n 27 is m er trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Ma 1-ewis Smith (brother) 211	alling Address (Street and Number or Rur. 70 Gueen Lanc Rock	al Route Number, City k Hall Ma	or Town, State, Zip LIJLCING 21	Code) 661	
ımore	Page 1 ar ment of He ant: If iter ury or oth		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State RA FCULA Completely, Cl RA FCULA	rematory or other place) S & Co Inc 01/20	1/2012 Ues		/Pennsylvani	
Бап	permit. Page Department of Important: If any injury or once.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		22. Name and Address of Facility ZCA 123 S Washington S				
~~	Physician/	o 1	23a. Part 1. Enter the disease or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
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P.O. Box 68/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown 9 Unknown 1 1 1 1 1 1 1 1 1	B		23d. Date of del Month	ivery Day Year	
IS, P.O.	uires that that signed by	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the		cco use contribute to the cause of death?			
Division of Vital Records,	The law requate has been page 2 shou	Somplete	CV*A		24a. Was an autopsy performed:	prior to d	copsy findings available completion of cause of 2 🏻 No	
Ita	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Hospital: The property of the property o	26. Place of Death (Chec	k only one)		~ .	
o to	ng Phys fter this ineral di	ite: To	1 ☐ Inpatient 2 ☐ ER/Outpat 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at	ome 5 Residence 28d. Describe how in		rty)	
/ISIOn	r Attendi ter death. irector: A ire by the fu	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 2	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street City or Town, Sta	(Street and Number or Rural Route Number,		
á	spital o		2ga, Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occured at the time, date and place, a	nd due to the cause(s)	and manner as sta	ited.	
	the Ho hin 24 h the Ful mpleted	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practioner: To the best of my knowledg	e, death occurred at the time, date and pla	ce, and due to the caus	se(s) and manner as	stated.	
	7 ₩ 6		29b. Signature and title of certifier	29c. License number		Date signed (Month	2012	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type		CHAN		71915	
	Sta		2533 AUGUSTINE HERMAN HWY 31. Date filed (Month JANe 2 3 2012) 32. Jegistrar's Signature	SUITE, A, CHESA	remce ch	(7, 101)	4113	
	Registr	ar	COLUIL COMMON B.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 20, 2012 0245 Veronica Regina Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll Lutheran Village Health Care Westminster Carroll 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-30-7329 **Director** 1 M 2X F Apr 14, 1932 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2X No Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 720 Velvet Run Ct. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Collectibles Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Agency Insurance Agent and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Regina Shepp Bartholomew Unsoeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 720 Velvet Run Ct. Westminster, MD 21157 Robert T. Smith, Sr/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🛂 Burial 2 🗌 Cremation 3 🗍 Removal from State Lake View Mem Park 1/25/2012 Eldersburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service I hasee 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause, Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death cerlificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 X ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending Investigation Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number answeigh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURLY A 349 Malwim 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #20b Per FH G924 2/15/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12 Martha Stacks Ann 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cifv. Town, or Location of Death Examiner IMOTE Sa If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/29/1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 M 2 DXF 213-42-4829 69 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Madical Experiment instituted and pines. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1√2 Yes 2 □ No Director Carroll MD Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21074 USA 1211 North Main St., Apt. 228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: white Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) real estate agent real estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Kerkoff Knight Elsie Catherine Schmitt ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1211 North Main St., Apt. 228, Hampstead, MD 21074 Roland Phillips Stacks, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/11/2012 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead Cemetery 1/10/2012 - Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee o M00741 934 S. Main St., Hampstead, MD 21074 emmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 VEAVS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: # 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29d. Date signed (Month, Day, Year) Eoo 29b. Signature and title of certifier 29c. License number P WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOO CATON AVE BALTIMORE MAS 21229 MODES

State Registrar 31. Date filed (Month, Da

		1	For State Registrar	State of Maryla		artment of H <i>rtificate of L</i>			giene Reg. No 2012	2 02782
-	Physicia	ın	1. Decedent's Name (First, Middle, La MAR LO N	S COTT	ST.	ARR		2. Date of Dea Month January	Day Yea 13, 2012	
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of De	eath
			Carriage Hill of			Bethes			Montg	
	Funeral		5. Social Security Number 6. S	I AM 2 T E	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day	9. E	Birthplace (State or Foreign Country)
	Director	-	333-01-1212 Usual Residence of Decedent	96	113.			March 2	1, 1915	Illinois
	and t		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ō	MD Mor	ntgomery	Kensi	Lngton				1 Tyes 2 No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
3	3ao		4017 Saul Road			20895			USA	
	ems (Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Race - Al Black, W	merican Indian, hite, etc.
<u>م</u>	or its		1 ☐ Never Married 2 ☑ Married	1 🖾 Yes 2 🗆 No If Yes, Give Year or Dates: 1944		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
215-0036	the filed within 72 hours after death with the Maryland Hygiene. Hygiene, ed other than "natural", or items 23a or 28a-f show et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced			dent's Usual Occup	ation		16b. Kind of Busine	ss/Industry
င်	"nat "nat	ete	15. Decedent's E (Specify only highest gr	ade completed)	(Give	kind of work done of DO NOT use retired	during most of work ()	ring		
7	withi iene. than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	l l	l Superin			U.S. Na	vy
0	Hyg other ent, i	Be C	17. Father's Name (First, Middle, Last	9			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
Maryland	should be nd Menta marked matic ev	To B	Larkin O. Star	5			Kathry	n Govai	.a	
a S	2 should to and Mental Is marked aumatic e		19a. Informant's Name/Relationship	Type. Print)					er, City or Town, Stat	e, Zip Code)
	es 1 and 2 should b of Health and Ment f item 27 Is marked r other traumatic e		Kathryn Mers Sta			Saul Roa			MD 20895	
o	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【□ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	THemovar from State M	etropoli	osition (Name of matory or other place Ltan Crema	tory		20c. Location - City Alexandria	ı, VA
alti	permit. Pages Department of I Important: If ite any injury or of		21. Signalare of Funeral Service Line	11111) 2F 5	2. Name and Addre rancis J. 00 Univer	ss of Facility Collins Sity Blv	Funeral	l Home Inc Silver Spr	ing,MD 20901
Sec.			23a. Part 7. Enter the disease, or conshock, or heart failure. List only	oplications that caused the do	eath. Do not en	ter the mode of dyir	ig, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fin	SEPS19						Oriset and Death
100	/Medical		resulting in death)	Due to (or as a cons	sequence of):					
	Examiner	_	Sequentially list conditions,	b	101 /A					
	Que e	ine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence or).					
6	ficate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					
8760,	s be e sician			d d						
	ificate g phy as the	edical								
Vital Records, P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
o.	that ned by deta	by Pr	Part II. Other significant conditions	contributing to death but not	resulting in the L	inderlying cause giv	ren in Part I.	23e. Did t	obacco use contribut	te to the cause of death?
<u>rd</u>	w requires been sign should be	q p	DIABETES MELI		MPORAL	ARTERI	115	1 🗆	Yes 2□No 3□	Probably 4 Unknown
Reco	sician: The law re s certificate has bee irector, page 2 sho	Completed	THROMBOPHLEBIT	is '					psy prior ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
ta	an: T tificat or, pa		25. Was case referred to medical	T			26. Place of Dea	1 Yes th (Check only o		165 2 100
5	ysicia is cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	ier: 4 Mursing H	ome 5□Resi	idence 6 Other (Specify)
0	ding Phys n. After this funeral di		27. Manuer of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time (of 28c. Inju	ry at rk?	28d. Describe	how injury occurred	
Ö	endin ath. or: Af	atio	2 ☐ Accident investigation	on		M 1	Yes 2 □ No			
Division or	or Att. ter de irecte n by t	Certification:	3 Suicide 6 Could not 4 Homicide determine		At home, farm, st ec <i>ify)</i>	treet, factory, office		28f. Location (City or To	Street and Number o wn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		200 Cortifier 17 Cortificion F	Physician: To the best of my	knowledge dee	th occurred at the fi	me date and place	and due to the	cause(s) and manne	er as stated
	Hos 24 ho Fun etely t	Medical		aminer: On the basis of exame and manner stated.						
	omple	Me	29b. Signature and title of certifier	•		29c. Licens			29d. Date signed (M	Nonth, Day, Year)
×	10+1		· Au UM	reps		5:	26571		1/14/12	~
	, -		30. Name and address of person which will be seen to see the seed of the seed	completed cause of death ((Item 23a) (Type	ORD ST =	#SDO KEN	JSING-TO!	N,MD 2	0895
	Sta Regist		31. Date filed (Month, Day, Year) JAN 17 20	32. Registrar's S	ignature de	del.				

12-00657 Sarah L. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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arah L. Smith	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No.
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year January 24, 2012 3. Time of Death 0623 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 27 Zion Acres Road 4c. County of Death Cecil
Funeral Director	5. Social Security Number 221-86-2776 1 M 2 X F 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. 18. Days Hours Min. 12/31/1994 9. Birthplace (State or Foreign Country) 12/31/1994
Aaryland 128-f show any 1.st once.	Usual Residence of Decedent 10a. State
r death with the N or items 23a or must be notified Funeral Dir	10f. Zip Code 10g. Citizen of What Country? 27 Zion Acres Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done)
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 11 Student High School 17. Father's Name (First, Middle, Last) College (1-4 or 5+) Student High School 18. Mother's Name (First, Middle, Maiden Surname)
imore, MD 21215-003 Pages I and 2 should be filed within ment of Health and Mental Hygiene. hant: Witen 27 is marked other th or other traumatic event, the Medi To Be Comp	Campbell Murray Smith, Jr. 19a. Informant's Name/Relationship (Type, Print) Mary Anne Smith/Mother 27 Zion Acres Road, North East, MD 21901
Baltimore, MI pemit. Pages I and 2 a Department of Health a Important: If item 27 injury or other traum.	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, 1 Annuery 2 Specify) or other place 2 Specify: 20c. Location - City or Town, State 2 Danuary 2 Specify: 20c. Location - City or Town, State 2 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 20c. Location - City or Town, State 3 Specify: 21. Signature of Funeral Service Licensee
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate 103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death In Epilepsy Due to (or as a consequence of): Due to (or as a consequence of):
0, be executed sician and burial - transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. AMENDED 23a, 27, per me, g925 3-29-12 sm
Certificate anding physics as the Cian/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 1 Unknown 1 Very 1 Ve
Records, P.C. The law requires that icate has been signed page 2 should be dear	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1
	examiner? 1
Divisi Divisi sepital or Att hours after de meral Direct y filled in by	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hos within 24 b To the Fur completely	29a. Certifiler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 3 3 3 3 3 3 3 3
ø	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registra	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 4:06 AM NORMA LORRAINE TRUBAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Cordova 12400 Blades Rd If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Min. 88 Director 235-36-1504 1 🗆 M 2 🗶 F Yrs 5-28-1923 WV Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Cordova MD Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 21625 USA 12400 Blades Rd death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 😾 No Specify: If Yes, Give White 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ella Culp Aaron Franklin Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 12400 Blades Rd Theodore L. Turban (Husband) Cordova, MD 21625 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Mem. Park 1-17-2012 Easton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERY ORONALV disease or condition Medical resulting in death) Due to (or as a consequence of RACTURE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examir attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ I or Attending Physician: The law requires that the death after death.

Director: After this certificate has been signed by the atten in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Examiner

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

Completed this certificate has ral director, page 2 funeral director, Be ပ

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No autopsy performed:

- 1 FNSTO1 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \) Other \(\text{Specify} \)

28d. Describe how injury occurred

28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier 29c. License number

se of death (Item 23a) (Type, Print) Railroad Avenue, Centreville 30. Name and address of person who completed car

State Registrar

Medical Certificate:

filled in by the

within 24 hours a To the Funeral C Hospital

31. Date filed (Month, Day,

25. Was case referred to medical

2 No

examiner?

27. Manner of Death

1 W Natural

4 Homicide

Accident

Suicide

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 8 2012 ear Physician/ Robert Mitchell Thompson 2:09 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Carroll County **Examiner** Westminster Dove House 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) (Month, Day, Year) **Funeral** Hours 1**X**] M 2 □ F 72 217-36-3460 Maryland Director Sep. Usual Residence of Deceden 3a or 28a-f show t be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Completed by Funeral Director Carroll County Hampstead Maryland 1 Yes 2X No 10f. Zip Code 21074 10g. Citizen of What Country? ms 23a must be United States 4620 Dave Rill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates.ietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status and Mental Hygiene.
is marked other than "natural", or iten aumatic event, the Medical Examiner r Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) tractor-trailer driver Elementary/Seconday (0-12) overland transport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miriam Mae Black ပ Edgar Mitchell Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620 Dave Rill Road Hampstead, Maryland 21074 M. Marlene Thompson / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 11, permit. Page 1 a
Department of H
Important: If ite
any injury or ott
once, 1 X Burial 2 Cremation 3 Removal from State Manchester, Maryland New Lutheran Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Hepatic Medical resulting in death) Due to (or as a consequence of): Examiner overload 10 obab iroh Sequentially list conditions, it any leading to in mediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours. Ster death.

To the Funeral Lirector. After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buri Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \) 2 \(\text{No} \) Ingations Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1. 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 015552 WJL 6+1VA 826 Washington Rd. Ste. 204 Wastminster, Md. 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saiontz M.D Howard 31. Date filed (Month, Day, Year) State JAN 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of M		partment of Health ertificate of Death	and Mental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)	g. No. 20 2	02786			
	Physicia Medic		Herman F. Thompson			2. Date of Death Month Tanuar	Day Year	3. Time of Death 4:04 AM
, cont	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c. County of Deat	
-	, 		University of Maryland Medi 5. Social Security Number 16. Sex 7. Aa	e (In yrs. last birthday)	Baltimore If Under 1 Year If Under	24 Hrs. 8, Date of Birth	l o Piw	hulan (Otata - Fari
	Funeral Director		219-44-8798 1 X M 2 □ F	65 Yrs.	Months Days Hours	Min. (Month, Day, Y	rear) Cou	hplace (State or Foreign Intry) ryland
	how at	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	Jun 16,	1940 116	10d. Inside City Limits
	farylar 8a-f sl tified	Director	Maryland Carroll			Windsor		1 Tes 2 No
	h the N a or 2 be no		10e. Street and Number		10f. Zip Code		ng. Citizen of What Co	untry?
	ath wit ms 23 must	Funeral	2660 Marston Road	Tues in LLC 10	217		USA	
ဖွ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by Fi	11. Marital Status 1 Never Married 2 Married 12. Was Decedent I Armed Forces? 1 Yes 2	No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexical	n, Puerto Rican, etc.)	14. Race - Amer Black, White	
21215-0036	ours af tural" al Exa	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates 1		1 ☐ Yes 2 No Specify.	:	Specify:	white
215-	א 72 hd an "na Medio	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give	edent's Usual Occupation e kind of work done during mos DO NOT use retired)	t of working	6b. Kind of Business/	Industry
	ed within Hygiene. other tha	Be Co	12)+)	Carpenter		Constr	uction
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Herman F. Thompson		18. Moth	er's Name <i>(First, Middle, Ma</i> uanita Clark	viden Sumame)	
ary	should be file and Mental H is marked of raumatic ever		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Number	er or Rural Route Number, C	ity or Town, State, Zig	Code)
	and 2 s Health em 27 ther tra		Herman F. Thompson III, son		0 Marston Road			
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Disp cemetery, cre	amatan, ar ather place)	/ /	Oc. Location - City or Westminste	
altir	permit. Page 1 a Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		22. Name and Address of Facili			·
8	Department of the service of the ser		Sustin R. Durboran		91 Willis Stre	eet, Westmins	ter, MD 21	157
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	d the death. Do not en	ter the mode of dying, such as	cardiac or respiratory arrest	i,	Approximate Interval Between Onset and Death
	Ph, sician Medical		disease or condition	ial Compa	ntment Syndron	ne		
2000	Examiner	L.	Sequentially list conditions, b. Gastric		7 days			
	ed nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury that injured events	a norasquende et;				-
	execul an and rial-tra	l Exa		a consequence of):	· · · · · · · · · · · · · · · · · · ·			
09,	that the death certificate be executed ned by the attending physician and e detached for use as the burial-transit	dical	d					
687	eath certifica attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of <u>pr</u> egnancy			23d. Date of del	iven
Box 687	e death the atter	Physician/Me	in the past 12 months?	2 Fetal death 3 t time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	nat the death ed by the atte detached for	Phy	g ☐ Unknown Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause given in Part	23e Did toba	acco use contribute to	the cause of death?
	v requires that been signed be should be det	ed by						obably 4 X Unknown
Sorc	has beer ge 2 shou	Completed				24a. Was an autopsy		opsy findings available
Re	: The la cate ha r, page					perform 1 \sum Yes 2	ed? death?	2 🗆 No
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ▼Ispatia	ent 2 ER/Outpatie	Other:	th (Check only one)		
of	Attending Physician: The law requires at death. sctor. After this certificate has been sign by the funeral director, page 2 should be	te: T	27. Manner of Death 1 ★ Natural 5 □ Pending (Month, Day	ry 28b. Time o		ursing Home 5 Residen 28d. Describe how		fy)
ion	ttendii death. tor: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐			
Division of Vital Records,	al or Atten s after deat I Director: ed in by the	Cer	4 ☐ Homicide determined 286. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
1	To the Hospital or Atwithin 24 hours after controlled the Funeral Direct completely filled in by	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of	xamination and/or inve	stigation, in my opinion, death or	courred at the time, date and	place, and due to the c	ause(s) and manner stated
	To the h within 2 To the F complet	Ψ	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	e best of my knowledg	e, death occurred at the time, da 29c. License number	te and place, and due to the	cause(s) and manner as d. Date signed (Month	s stated.
	11154		Andry Jan, Mil		1710286		anusy 7	
	NA		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)			
	Stat	te	Windsen fan 22 Son 31. Date filed (Month, Day, Year) 32. Registra	th Greene ar's Signature	DAIT	smore MD s	21201	
	Registra	ar	JAN 0 9 2012 Denu	un B. x	backer			

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State of Maryland / Department of Health and Mental Hydiene

		1	For State	State of Marylan		artment of H tificate of D			Reg. No. 2 ()	12 02787
	Dhusisis		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	th	3. Time of Death
	Physicia Medic	al	Wilbert Jos		<u>.</u>	4b. City, Town, or I	Leasting of Dooth	January	7, 2012	
	Examin	er	4a. Facility Name (if not institution, give st Woodside Center	rreet and number)		Silver				gomery
	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
H.	Director		578-70-0355 Usual Residence of Decedent]M 2□F 60	Yrs.			July 11	, 1951	Washington, DC
	land show dat	tor	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	e Mary 28a-1 notifie	Director	MD Prince Ge	orges Ri	verdal	e 10f. Zip Code			10g. Citizen of W	1 Yes 2 X No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	eral [4813 Ravenswood R	oad		2073	37		USA	vilat Godinay.
	items	12	11. Wantai Otatus	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
36	after al", or	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		I ☐ Yes 2 🛣 No			Specify:	
9-0	hours natura dical E	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Deced	dent's Usual Occupa kind of work done di	ation	kina	16b. Kind of Bu	usiness/Industry
121	within 72 giene. ter than " t, the Med	Juno;	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Di	O NOT use retired)			Capital	L Office Park
d 2	filed wit al Hygie d other event, th	a l	11 17. Father's Name (First, Middle, Last)		Harine	Chance Bi	18. Mother's Nam	ne (First, Middle, I		
/lan	should be file n and Mental I 7 is marked o raumatic eve	임	Wilbert J. Thomas	, Sr.			Mabel			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has a marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type Barbara A. Thomas			ng Address (Street a				state, Zip Code) y1and 20737
ē,	je 1 and 2 t of Healt If item 2 or other		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of		Date		· City or Town, State
mo			1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place oln Cremat				ood, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign fur of Funeral Service License	M01102		Name and Address 040 Rockv		Simple : e, Rockv		aryland 20852
	TEL	П	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	ications that caused the deat e cause on each line.	th. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Acute Rena		ure				Onset and Death days
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		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq						
	cuted	Examine	Cause (Disease or injury that initiated events	uence of):					days	
0	cate be executed physician and the burial thankit	edical E	resulting in death) Last	200 10 101 00 0 001000	301100 01).					
3760	ficate ig phys as the	Medi	IE EEMALE:	u						
Box 687	death certific ne attending p led for use as	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live Birth 2 Fet	al death 3	Ectopic pregnanc	:y			ite of delivery onth Day Year
	hat the death certific ed by the attending p detached for use as	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 L	Other (specify)				
s, P.O.	law requires that the nas been signed by the e 2 should be detach	þ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the t	underlying cause giv	en in Part I.			ribute to the cause of death? 3 Probably 4 Unknown
ord	w requisite been 2 shou	Completed						24a. Was a	osv I	Were autopsy findings available prior to completion of cause of
Rec	The ate l	Com						perfo 1 Yes	rmed? 2 X No	death? 1 Yes 2 No
ital	ysician: The is certificate director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 N No	lospital:] FD/O +	Othe	ace of Death (Che		6 D Oth	er (Crosife)
of Vital Records,	ng Ph fter thi ineral	ate: To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time o injury	f 28c, Injury work	y at	10me 5 Resid	ow injury occurr	
Division	I or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif			res 2 🗆 No	28f. Location (S City or Tow		er or Rural Route Number,
		1 -			vledge, death	occurred at the time	e, date and place,	and due to the ca	ause(s) and man	ner as stated.
_	Hospital or 24 hours afte Funeral Dire etely filled in	edical	29a. Certifier 1 X Certifying Physic (Check 2 Medical Examination of Certifying Nurse)	ner: On the basis of examination	on and/or inves	stigation, in my opinic	on, death occurred	place and due to t	he cause(s) and r	e to the cause(s) and manner stated.
_	To the Hospital or within 24 hours after To the Funeral Dire completely filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the filled in the following the	Medical	(Check 2 Medical Examin	ician: To the best of my knov her: On the basis of examination e Practitioner: To the best of	on and/or inves	stigation, in my opinic	he time, date and p e number	place, and due to t	he cause(s) and r 29d. Date signe	nanner as stated. d (Month, Day, Year)
_	To the Hospital of within 24 hours a To the Funeral D completely filled	Medical	(Check only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier 30. Name and address of person who occur	per: On the basis of examination a Practitioner: To the best of th	on and/or investing knowledge	29c. License D685	the time, date and per number 583	ford, M.	he cause(s) and r 29d. Date signer 1/11/ D.	nanner as stated. d (Month, Day, Year)
_ _	To the Hospital within 24 hours a To the Funeral D completely filled	Medical	(Check only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	per: On the basis of examination a Practitioner: To the best of th	m 23a) (Type,	print) Tany	the time, date and per number 583	ford, M.	he cause(s) and r 29d. Date signer 1/11/ D.	nanner as stated. d (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death ^D2012 Physician/ Jan. 17, 11:30 P M Ralph Joseph Vendemia, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate House If Under 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Social Security Numbe 7. Age (In vrs. last birthday) Days Hours (Month, Day, 1 ₺ M 2 🗆 F Months Min. Columbia, Director 216-22-2178 84 1927 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location within 72 hours after death with the Maryland Director 1X Yes 2 No Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20785 6103 Cheverly Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 图 Yes 2 No 8/1945
If Yes, Give Year or Dates, 8/1948 Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White Specify: "natural", 3 Widowed 4 Divorced Completed . Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) John Hopkins College (1-4 or 5+) Elementary/Seconday (0-12) Aeronautical Engineer Physics Engineering Masters Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Lagana Ralph Joseph Vendemia, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille M. Vendemia - Wife 6103 Cheverly Circle, Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott cemetery, crematory or other place 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Adelphi, Maryland George Washington Cemetery 1/23/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses 4739 Baltimore Avenue MD 20781 Gasch's Funeral Home, P.A. Hyattsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Acute Lymphocytic Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year page 2 should be detached for 5 Other (specify) 1 Yes 2 9 Unknown 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate 1 Yes 2 X No Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 🔀 No Other: ᅆ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🗓 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred s after death. injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) steen D23743 1/18/2012

State Registrar

15, c/M/0

may

31. Date filed (Month, Da

JAN 2 0 201

Martin D. Weltz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Dr, Ste 206, Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Geneva Kay Wicker January 6:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House-Montgomery Hospice Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month Days 579-84-7493 **Director** 1 □ M 2 🛛 F 54 Nov. 26,1957 0klahoma Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Gaithersburg Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 407 Suffield Drive 20878 USA oe filed within tental Hygiene.
arked other than "natural", or items.
vent, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) 12College (1-4 or 5+) Day Care Provider Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Otho Reel Jeanette Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Suffield Drive, Gaithersburg, MD 20878 Douglas E. Wicker/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or oonce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 01/16/2012 | Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Metastatic Colorectal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Suicide Investigation

P and burial-t physician law requires that the death certificate be Box 68760 as the attending use for detached P.O. ģ been signed be should be deta Division of Vital Records, has certificate • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certified upletely filled in by the funeral

ms 23a or 28a-f show must be notified at

or items

traumatic event,

marked

and N

1 and 2 sof Health

with

within 72 hours after death

Baltimore, Maryland 21215-0036

Certificate: Medical To the within 2 3 State

Bindu Joseph, MD, 1160 Varnum St. NE #021, Washington, DC 20017 31. Date filed (Month, Day, Year) JAN 17 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Registrar

1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0060634

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year.

January 13, 2012

12-00631 John White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

om wine		State Of Maryland / L 1-For State Registrar	Certificate o		iu ivientai n		eg. No. 201	2 0279
Physicia Medical Examii		1. Decedent's Name (First, Middle,Last) John R. Wi	nite			2. Date of Dear Month January 2		3. Time of Death 0924 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital		4b. City, Town, o	r Location of Deat		4c. County of Dea	th
Funeral			yrs. last birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9. B	
Director		204-40-4002 1√x M 2□F	62 Yr	Months Day	ys Hours Mir	12-31-	1949 Fore	ountry) PA
ku			c. City, Town or Loca					10d, Inside City Limits
ryland a-f show	tor	PA Adams A	Arendtsvi				0g. Citizen of What Co	1XX Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inti. If item 27 is marked other than "natural", or items 23a or 28a-f above the traumatic event, the Medical Examiner must be notified at once.	i Director	123 Queen Street		10f. Zip Code	17303	"	USA	antry?
eath wit	Funera	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X	lf.		ispanic Origin? (S ın, Mexican, Puerto		White, etc.	rican Indian, Black,
s after d	by Fu	3 Widowed 4 Divorced If Yes, Giva Yaar or Dates:	1	Yes 2 No			Specify: Wh	
72 hour	eted	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)	during n	nost of working life	ation (Give kind of e. DO NOT use ret		16b. Kind of Business	/Industry
-003(I within grene. ther tha	Completed	12 5+	Atto	orney at	Law 18.Mother's Name	e (First Middle N	Legal	
21215-0036 unid be filed within 7 Mental Hygiene. marked other than	Be	John W. Whi			Но	ope Spic	er	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa	ဥ	19a. Informant's Name/Relationship (Type, Print) Tonya Knouse White / wife	19b. Mailin	Box 47	et and Number or 2 2 Arendts	Rural Route Num SVIlle,	nber, City or Town, Stat PA 17303	e, Zip Code)
ore, les 1 and of Healt if item		20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	20b. Place of Dispo crematory or o	sition (Name of ce	emetery,	Date	20c. Location - City o Arendtsvil	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee					oraw Funer	_
		Justin R. Durboyce	91	Willis	St. Westr	minster,	MD 21157	
Physician /Medical		 23a. Part I. Safer the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a. Atheroscler 					est, snock, or neart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a conseque		10 140041	ur Dibed	<u> </u>		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	nce of):					
nsi se d	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a conseque	nce of);					
50, te be execu ysician and burial - tra	Medicai	M UNPENDED 23a, 2 23aPt] ∴ AMENDED 23a, 2	27, per me	,g924, 2	-3-12 sm	1/05/201	2dhh	
8760, tificate be ng physici as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth	f pregnancy		Ectopic pregna		23d. Date of deliver	ry Day Year
30x 687 death certifica re attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	of dooth	ther (Specify)				
that the red by th	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause	given in Part I.		bacco use contribute to	
ds, P.(requires that		Traumatic head injuries				24a. Was a		utopsy findings available
Recol The law cate has l	Completed				-	autop: perfor	med? death?	completion of cause of
ician:]	BeC	25. Was case referred to medical examiner?			e of Death (Check			
of V ing Phys After this	임	1 ✓ Yes 2 No The imparient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien 28b. Time of		4 Nursir	28d. Describe h	Residence 6 Other One of the Other O	100 000 00
Sion Attendi r death. ector: /	catio	Natural 5 Pending 01/15/201 2 X Accident 5 Pending Investigation 28e. Place of Injury		- I	Yes 2 X No	head on	the sidew	
Divi	Certification	4 Homicide determined (Specify) S	idewalk	et, lactory, office	building, etc.	or Town, S	tate) Annapoli	s,MD
	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowney Certifying Physician: To the best of my knowney Certifying Physician: To the basis of examinar	wledge, death occu	irred at the time, d	late and place, and	I due to the caus	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To To con	Mec	and manner stated. 29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mo	
		Oure SC	(Horn CC-)	O.C.	M.E.		January 24, 201	2
		30. Name and address of person who completed cause of death Ana Rubio MD. Assistant Medical Examine	er 900 W. Ball	timore Street,	Baltimore, MI	21223		
Sta Registi	ate	31. Date filed (Month, Pay Year) 32. Registrar's Si	grature /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 2:10A M **Physician** January 2012 Deulah Novella /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Aurora Senior Living of Manokin Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Days Director -16 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nem z/ is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Pres 2 □ No **Funeral Director** ambridg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 16/3 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 12 Ño ģ If Yes, Give Year or Dates: Specify 3 ₩Widowed 4 □ Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) tealth Nurse 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s St of Health a De1. Minaton 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lecation - City or Town, State Date Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 120/2012 ans Cemetery 4 Donation 5 Dother (Specify) urlock. 22. Name and Address Facility
Henry Funeral Home, P.A.
Siowashington Stacambridge, MD, 21613 21. Signature of Funeral Şervice Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASWA disease or condition resulting in death) Sycars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liquily that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the at d be detached for o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy performed 2 No 1 □Yes Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2 and manner stated 29b. Signature and title of certifier 29c. License number

State Registrar in he nah

DR. USHA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

NATESAN

1

K106/41

Jewah Young

Baka

1415 . S. DIVISION ST,

005/359

SALISBURY

2/804

			For State	State of Ma	aryland /	Departmen Certificate			nd Mental Hy		201	2 0279	4
		9	Registrar 1. Decedent's Name (First, Middle,	Last)		Certificate	- 01 De	Jalii	2. Date of D			3. Time of Death	-
	Physicia Medic		Joseph H. Yate:	r, Jr.					Janua	ry L	2 3 gear	2 0255 M	
<u>ب</u> حمر	Examin	er	4a. Facility Name (if not institution,	Hos Pital		4b. City,	Town, or Lo		Death	40	County of De		
	Funeral				(In yrs. last bi	irthday) If Under	1 Year	If Under 24			9. B	irthplace (State or Foreign	-
1	Director		157-14-7042	1 X M 2 □ F	86	Yrs. Months	Days	Hours	Min. (Month, D			(ountry) MD	
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location					1	10d. Inside City Limits	-
	Maryll 28a-f otifiec	irect	MD Talb	ot	Tr	appe						1 Yes 2X No	
	ith the 3a or st be n	ralD	10e. Street and Number 30932 Brucevil	la Rd		10f. Zip	Code 21673				tizen of What 0 SA	Country?	
	eath w	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.			anic Origi	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Am	nerican Indian,	-
36	after d ", or i camine	by	1 Never Married 2 Marrie	Armed Forces? 1 X Yes 2 1 If Yes, Give	Vo	1 Yes, spec			Puerto Hican, etc.)		Black, Wh	ite, etc. Thite	
21215-0036	hours natura ical E	Completed	3 X Widowed 4 Divorced		166	a. Decedent's Usua				16b. K	(ind of Busines		_
215	nin 72 ne. han "r e Med	dwo	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4 or 5-	+)	(Give kind of wor life. DO NOT use	retired)		of working				
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lan	d be fill dental irked o	2	Joseph H. Yate						zel Floren	,	,		
Maryland	should nand N is ma	1	19a. Informant's Name/Relationshi		17.1	9			or Rural Route Numb			Zip Code)	
e, P	and 2 Health tem 27		Joseph F. Yate 20a. Method of Disposition	r (Son)		of Disposition (Nam		Te Ko	Trappe		ocation - City o	or Town, State	_
E O	Page 1 Tent of Int: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	Removal from State	cemet	ery, crematory or of awn Mem.	her place)	1	-17-2012	1	ston, M		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Fund I vervice Lin	- A	DEL	22. Name and Fellows	d Address	of Facility If ent	oein & New	nam	Funeral	Home, P.A.	-
	00 = 0		23a. Part 1. Enter the disease, or o	complications that daysed	the death. Do	1 1200 S.	Harr	ison	St. Easto	n MD	21601	Approximate	
£.	h sician/		shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line.	Acut	Res a.	~ 1.	^	Carline			Interval Between Onset and Death	
ب	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	consequence	e of):	. 10	7					-
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):	1						_
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C	·	Cof	, V					ŀ	
	cate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence	e of):							
760	cate b physical	edical		d									
× 68	eath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		th 3 🗆 Ectopic p	regnancy				23d. Date of d	lelivery	
Bo	e death the att hed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at g ☐ Unknown							Month	Day Year	
Division of Vital Records, P.O. Box	requires that the des been signed by the s should be detached	by Ph	Part II. Other significant condition	s contributing to death bu	it not resulting	in the underlying c	ause given	in Part I.	23e. Did	tobacco (use contribute	to the cause of death?	
ds,	quires en sigr ould be	ted b							1□	Yes 2	□ No 3 □	Probably 4 Unknown	
COL	law re has be e 2 sh	Completed							24a. Was	ppsy	prior to	utopsy findings available completion of cause of	Ī
Re	sician: The law is certificate has birector, page 2 s		25. Was case referred to medical				OC Plant	f D sh	1 ☐ Yes	ormed?	death?	es 2 🗆 No	_
Vita	Physicia this certi ral direct	To Be	examiner?	Hospital:	nt 2 ER/O	Outpatient 3 DC	Other:		(Check only one) sing Home 5 Res	idence 6	3 ☐ Other (Spe	ecify)	-
1 of	al or Attending Phy s after death. I Director: After this d in by the funeral c		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day,		injury	Bc. Injury a work?	t	28d. Describe				
Sior	Attend death ctor: A	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	v - At home, f	farm, street, factory,		s 2 🗆 N		Street an	d Number or B	Pural Route Number,	
	tal or /		4 Homicide determin	building, etc.		,,			City or To			.,,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi.	Medical	(Check 2 \(\sumeq\) Medical Ex		amination and/	or investigation, in n	ny opinion,	death occi	urred at the time, date	and place	e, and due to the	e cause(s) and manner state	
	To the within To the comple	Σ	only one) 3 Certifying I 29b. Signature and talle of certifier	Nurse Practitioner: To the	best of my kno	29c.	License no	umber		29d. Da	te signed (Mon	eth, Day, Year)	
			· (44)	M-0.		D	9\$6	262	5	Ja	mey	12,2012	
, ,			30. Name and address of person w		ath (Item 23a)	(Type, Print)	4	د	Short F	E1+) A	12,2012 ND 2(601	•
H	+VA Stat	e	31. Date filed (Month, Day, Year)	16-15 2 32. Registrar		1.	7	-	-1-40)	J	٠٠, حد		-
			# N H J # 77	4131 7 1 P)	65	A 100 A 100 A 100 A							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:40 A M Michael Arthur Bull February Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Casey House 8. Date of Birth If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min Days Months Jamonth Bay, 1941 England 578-60-3466 71 1 X M 2 □ F **Director** Yrs Usual Residence of Deceden 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State with the Maryland notified at Director 1 🗆 Yes 2 😾 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ms 23a or must be n Funeral 12704 Holdridge Road 20906 England 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ō þ Yes filed within 72 hours after al Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes Give Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) TMR Corporation the Environmental Engineer other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ၉ (unk) A. A. Bull Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12704 Holdridge Road Silver Spring, MD 20906 Betty Bull/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 02/03/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksvillo, MD 21020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death signed by the aid be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopu, performed? 2 No page 2 🗌 No 1 🗌 Yes 2 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6X Other (Specify) hospice 1 🗌 Yes 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A steely filled in by the fi Investigation 2 Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year)

ION

Registrar
DHMH 17 Rev 06-2011

Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R143201

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 1 tem 30 per doc 9924 2-22-12 vt State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 1, 2012 8:47 A M Heinz Egon Blum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 2103 Aventurine Way If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 91 **Director** 577-50-7695 1**X** M 2 □ F Nov 24, 1920 Germany Usual Residence of Decede show 10d. Inside City Limits 10a. State 10c. City, Town or Location at with the Maryland Director notified 28a-f MD Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be r Funeral USA 20904 2103 Aventurine Way death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deces? Armed Forces? Ves 2X No 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 XMarried Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Electronic Engineer Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is meany injury or other ည Marie Gertrud Müller Hugo Blum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Blum/wife 2103 Aventurine Way Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 02/04/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) a Superior Vena Caval Syndrome Medical Examiner Non Small Cell Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 XNo 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Centifying Nume Practitioner: To the best of my included a count occurred at the time, date and place, and place, and place, and place, and place and place, and place and place and place and place and place. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D20367 February 2, 2012 30. Name an Karleman person who completed cause of death (Item 23a) (Type, Print) Joel Lalman, M.D. 1396 Piccard Drive Rockville, MD 20850 IDV

State

Registrar

31. Date filed (Month, Day, Year,

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32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Genevieve Helen Becker FERRUARY 08:00 AM ZOIZ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SINAI HOSPITAL OF BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. (Menth Day & 1922 Hours New York 215-12-0338 1 - M 2 X F **Director** Usual Residence of Dec show 10a. State 10h County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 1 Yes 2 No 28a-1 Baltimore Parkville or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be or items 23a 7707 Bagly Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14 Bace - American Indian item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗖 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Rowley Genevieve Unk permit. Page 1 and 2 should Department of Health and M Important: If Item 27 is mar any injury or other traumat once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Becker / Granddaughter 3612 Mary Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Preb 06 1 Burial 2 Cremation 3 Removal from State Timonium, Maryland Dulaney Valley Memorial (2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. NaGrenation and Funeral Alternatives Poboco 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
2 DAYS shock, or heart failure. List only one cause on each line Immediate Cause (Final PNEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEPSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? Jas perform Hospital or Attending Physician: The Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending n 24 hours arter control Affi he Funeral Director: Affi 2 Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicions: The first of my months of the cause of 29a. Certifier (Check 29b. Signature and title of certifier D0069021 FEBRUARY 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE MD SINAI MICE State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2, 2012 John C. Buser, Jr. 8:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death St. Joseph Nursing Home Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 216-28-5506 Months Days Hours **Director** 1 X M 2 | F Oct. 17, 1931 Maryland 80 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ellicott City MD Howard 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 9724 Gudel Drive 21042 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene. ?7 is marked other than "natural", or iten traumatic event, the Medical Examiner r 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h 2 John C. Buser, SR. Anne L. Klein and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9724 Gudel Drive; Ellicott City, MD 21042 Patrick Hall Nephew tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 2/7/2012 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Ligense Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ alute disease or condition Medical resulting in death) Due to (or as a consequence of Examiner sears if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence attending physician Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? detached for Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform Hospital or Attending Physician: The I
 24 hours after death.
 Funeral Director: After this certificate h 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury Accident Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 32158 2012 30. Name and address of b lling Road, Ste 108 catonsville Lyonn

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GASTON BOOKER Lucius Feb 20 hrsM 2012 Medical 4a, Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 496-18-8874 Director 1 🕱 M 2 □ F 89 February 10,1922 Missouri 28a-f show aţ 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Maryland Howard 1 Yes 2XX No Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5204 Even Star Place 21044 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 2 X No Maryland 21215-0036 er than "natural", the Medical Exan 1 ☐ Yes 2 🔭 No Specify. Specify: 3 Widowed 4 Divorced Completed Black. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Drug Enforcement Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lucius Booker Florence E. Baker traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma June Booker If item 27 (Wife) 5204 Even Star Place Columbia, Maryland 21044 other t Baltimore, Department of Healimportant: If itemany injury 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 2-6-2012 Clarksville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final CEREBRAL KNOWA Onset and Death Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CEREBRAL INFARCT Sequentially list conditions Due to for as a consequence of If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed CARDISPULMINARY ARREST and -trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown 9 I Inknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TONSILAR CANCER Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COLON CANCET 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas performed' certificate PULMONARY EMBOLISM 1 🗌 Yes 2 🗌 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. neral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0043662 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Year 5.46 PM Carpen Maro Brawn Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death NIA Baltimere of Marchand Medical Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) 214-60-**Director** 1 M 2 F 19 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Ves 2 No 10e. Street and Number 10f Zip Code ms 23a or must be r o 10g. Citizen of What Country? Funeral 2107 items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? Black, White, etc. ò ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates Black "natural" Completed 3 Widowed 4 Divorced traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) *care* and Mental Hygie is marked other Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cann Moody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Monige MOVIC Óι other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth . Page 1 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, Hartoc Memaral 12012 4 Dopation 5 Other (Spedity) ur of Funeral Servi owed It's male 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Sepsis disease or condition Medical resulting in death) Due to (c as a consequence of): Examiner Abdomial wound Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant
Unknown 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy page 2 2 No 1 Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ X Yes 2 No 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) AV4176435618268 2012 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Singl

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Bloodgood 8:15 P M David Titus 02 01 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel Severna Park Genesis Elder Care Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Days Months 059-20-0782 **Director** 1**X**XM 2 □ F 87 07/25/1924 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Anne Arundel Severna Park MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral USA 21146 149 Drexel Drive death v "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes. Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2XXNo Specify: White ¾X Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) Chemical Engineer Marine Coatings 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Flora Jackson Bloodgood David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 Woodridge Place Laure1, MD 20724 Mr. Peter Bloodgood/ Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 XXremation 3 ☐ Removal from State Glen Burnie, MD 21061 Atlantic Crematory 02/03/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 MO1479 Similare of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Discase Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to lor as a consequence of it any leasting to immedi cause. Enter Underlying Cause (Disease or injury for use as the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the saluding should be detached 1 L Yes 2 L 9 L Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 № No 3 □ Probably 4 □ Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 🗌 Yes 2 🗆 No after death.

Director; After this certificate 1 Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) To Be examiner? 2 **1** No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28d. Describe how injury occurred 28c. Injury at work? Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely only or 29c. License number R 1331 No 29d. Date signed (Month, Day, Year) 29b. Signatur

State Registr<u>ar</u> death (Item 23a) (Type, Print) BUD. Ellen BUNNU, My 2106/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Marguerite Helen Boulden 8:15 AM Medical January 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore Paradise Assisted Living Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 1 M 2 XF Days Hours 215-14-4797 91 **Director** January 29,1921 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b County at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director must be notified Baltimore Arbutus 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5556 Ashbourne Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White ō 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: "natural", 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail l Hygien other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ၉ Lehman Byron Schaeffer Helen Elizabeth Gemmill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Leidig-Friend/POA 5558 Ashbourne Road, Arbutus Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Feb. 3, 2012 | Baltimore Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Ambrose Funeral Home Inc. Sulphur Spring Road Arbutus Maryland 21227 328 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Deat Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 N 1 Tyes 2√ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred work? 1 Natural 5 Pending injury Director: A d in by the ft Accident Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of 29d. Date signed (Month, Day, Year) 365 2012

State Registrar (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 7:30 A M ALVIN BLUM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOWARD LORIEN NURSING HOME 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Hours Min. 1171771918 Director 212-05-8589 93 MD Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 X No COLUMBIA HOWARD MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 6334 CEDAR LANE, 21044 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Married 1X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) SALESMAN INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ETTA **JACOBS** SIMON Η BLUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA BLOCKER/DAUGHTER 34-B BRIAN DRIVE, STOUGHTON, MA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/01/2012 OWINGS MILLS, MD 4 Donation 5 Other (Specify) HAR SINAI CEMETERY Signature of Euneral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Separate at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes the Hospital or Attending Physician: I hin 24 hours after death.
the Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 INO မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **♦** Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical New Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spore 00053150 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

X DHMH 17 Rev 7/2009

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2. Registrar's Sign ure

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death JOSEPHINE BELCHER Medical FEBRUARY 11:16 A M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A Funeral . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Director Birthplace (State or Foreign Country) 212-30-6169 Months Days 1 □ M 2**X** F 78 Usual Residence of Decede March 13,1933 28a-f show Maryland Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Dunda1k 1 Yes 2 XNo 23a or 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 7626 Crescent Avenue 21224 "natural", or items United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Black, White, etc. 3x Widowed 4 ☐ Divorced Completed 1 Yes 2 X No Specify. Year or Dates. Specify event, the Medical White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Sales Representátive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Anthony Vallario Letizia V. Ciberelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 8310 Cove Road Dundalk, Maryland 21222 permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra Mrs. Terri A. Rigsby (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Donation 5 Cother (Specify) Entombment Gardens of Faith Date 20c. Location - City or Town, State 2/4/2012 Baltimore, Maryland Signature of Funeral Service Licensee ²Duda≞kuck°funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease. Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Physician/ Interval Between disease or condition 10 dic Onset and Death Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month 9 Unknow 9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician; The law requires Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Division of Vital 25. Was case referred to medical Be Yes 1 Yes 26. Place of Death (Check only one) 2 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred 5 Pending 124 hours after deatle Funeral Director: Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) RES-000 FEBRUAR

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State Registrar GOO NORTH WOLFE ST, BALTIMORE, MD 21289

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Examiner	4	a. Facility Name (if not institution, g		e.				Location of De		4	c. County of Dea		
Funeral Director		Social Security Number 218-32-4249 Usual Residence of Decedent	Sex 7. Age 1 □ M 2 X F	(In yrs. la	ast birthday) Yrs.	If Under Months	Days	If Under 24 H Hours N	8. Date of E (Month, L) 3 / 18 /	Day, Year)	C	irthplace (State or Foreigr ountry) S • C •	
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21215-003 Juithin 72 hours a ygiene. her than "natural" it, the Medical Ex		15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8th	grade completed) College (1-4 or 5- N/A	+)	16a. Deced (Give i life. De Dome:	kind of wor O NOT use	al Occupa rk done d e retired)	ation luring most of v	vorking		Kind of Busines:		
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Baltimore, Maryland Pernit. Page 1 and 2 should be filed Department of Health and Mental Hy mportant: If item 27 is marked out any injury or other traumatic event any injury or Other traumatic To Be		19a. Informant's Name/Relationship Hazel Chishol 10a. Method of Disposition	m-Daughte			E. :	Lafa		Rural Route Numi Ave • I	Balt		MD 21213	
Iltimor nit. Page 1 artment of ortant: If it injury or c		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spectrum of Funeral Service Lice	cify)	0	emetery, cren butus	Mem	ther plac • Pa	ark 2/	3/2012	На	lethor	pe, MD 01 E. Nor	
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Physician/ Medical		23a. P 1. Enter the disease, or co s ock, or heart failure. List only lm diate Cause (Final dise se or condition resulting in death)	a. Due to (or as a			er the mode	e of dying	g, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death 23 days	
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De ey purian buria		Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	uence of):									
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medic	122	FFEMALE: :3b. Was decedent pregnant in the past 12 months? 1	1 Live Birth 2	23c. If yes, outcome of pregnancy 1								elivery Day Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elsie Colona Month January 2012 1:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death Envoy of Pikesville Pikesville Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 😾 F Days 7-19-192^(ear) 216-18-0020 89/rs. **Director** MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified MD Baltimore 1 ☐ Yes 2 🌠 No Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 6980 Rockfield Road 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes, Give X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African-American Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Social Security Adm. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oscar Shorter Sr. Janie Henson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6980 Rockfield Rd., Windsor Mill, MD 21244 Kim Parker/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State King Memorial Park 2-2-2012 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Palto. Co. e of Funeral Service Lice 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each pe. Approximate Interval Between Onset and Death Immediate Cause (Final Physici_n FAILARE TO THRIVE disease or condition Medical resulting in death) Examiner BEMSMITH 12MOS Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be LEGAL BLINSNESS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2.2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AUENCE #203, BOLTHONE, MANY/AND 21209

DHMH 17 Rev 7/2009

State Registrar KATHUSEN C. DIAMMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stephen Alan Campbell 5:45 01 2012 AM 00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death nospital Good Samanton Balhmaro. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 | 23 | 19 4 7 **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 M 2 □ F Days Months Hours 220-42-8537 CountyD Director 64 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Gwynn Oak 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3818 Byfield Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

11 Yes 2 □ No if Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Tyes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: African-American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Real Estate Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enginee. ၉ Raymond Campbell Betty J. Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antionette Campbell/Wife 3818 Byfield Road, Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Veterans 20c. Location - City or Town, State 1 \overleftarrow{X} Burial 2 \square Cremation 3 \square Removal from State 2-8-2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Servi 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. (7). 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ VICSEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page performed? Yes 2 ☐ No After this certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of the Hours a To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Sched. MD. 02/01/2012 RES - 000. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Anonta Subed

31. Date filed (Month, Day, Yea

mb

stephen Campbel

Good Samaritan hospital, 5609 Loch Raven Blvd Ballimore, mp, 21239.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02806 State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 28, 2012 James R. Chaney 1:00 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pasadena Anne Arundel 203rd St. 773 Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 214-38-446 Hours Mir 1 M 2 □ F Months 10 10 . 1<u>942</u> 9 Yrs Maryland Director June Usual Residence of Decedent or 28a-f show notified at 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 203rd Street U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 No 1959 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 1965 the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 6 N/A ABF Trucking Truck Driver other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Milton John Chaney Estelle Elizabeth Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JoAnn C. Chan</u>ey (Wife) 773 203rd Street Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/03/2012 | Glen Burnie, Maryland Atlantic Cremation . Signature of Fyneral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death ACUTE Physician/ MYOCARDA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events and r burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No After this certification funeral director, p Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 □ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury hours at er death. 1 🗌 Yes 2 🗌 No the Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the F only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 163632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Son A Kun AH mp. 505 LANDMARK DL. 55 128, GB, mb 21061 KUMAH mp

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

FEB 0 3 2012

32. Registrar's Signature

1 - For State Registrar

Director

Funeral

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attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s been signed by the sahould be detached has page within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag

25. Was case refe examiner? 1 🗌 Yes 27. Manner of De 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation in my calculated the cause (s) and manner as stated. 29a. Certifier Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cyrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one)

29b. Signature and title o certifie 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 GRIFFIN DAVIS HOSPITAL DRIVE CHEVERLY 20785 MD

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State

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Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02808 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 1, 2012 Rosalie Mary DeCesare 7:42 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4697 Doncrest Court Carroll Sykesville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 215 22 4344 **Director** 1 M 2 X F 86 SEPT 10 1925 show 10a, State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f KESVILLE CARROL Ma 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? must be r Funeral USA 1704 ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural". Completed 3 Widowed 4 Divorced WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOMEMAKER OUN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM CATHERINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau BERNADETTE N -NONCREST CT SYKESVILLE MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4/2012 4 Donation 5 Other (Specify) MARZIOTTSVILLE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility NZUMBWN FHE MON Co-6028 SYKESVILLE RD ELDERSBURG-MVD 21784 23a. Vart V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death DEMENTA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTEWSION Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transi AGE resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy signed by the atter in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performe certificate 1 Yes 2 No Yes 2 No ours after death.

eral Director: After this certificalled in by the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Funeral Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29c. License number

State

Registrar

7190 GRESTWOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN

FEB 03

MD

20055154

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day MARIE CATHERINE Month Year FOREMAN 920 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FRANKLIN SQUARE HOSPITAL Center Rosedale Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗀 🕏 Days Hours Min. 1-6-1942 Months 218-36-6068 MARYLAND Director 70 Usual Residence of Decedent f show or 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD ROSEDALE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 16 WEYFIELD COURT 21237 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ Xio Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) HOMEMAKER OWN HOME Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, CATHERINE (F WILLIAM McEVOY ပ KLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GUY FOREMAN/SON 16 WEYFIELD COURT ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 2-4-12 BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Pnysician/ Cardiopalmonary Medical resulting in death) Due to (or as a consequence of): **Examiner** Failur Sequentially list conditions, cause. Enter Underlying Exam a Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.
24 hours after death.
24 hours after death.
24 hoursal Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit eleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury m etastic B-cell that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed' 1 Yes 2 No Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one within To the

None

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

madanieh

29b. Signature and title of certifier

DRRQEF

32. Registrar's Signature

29c. License number

9000 FRANKLIN SQUARE DR

RES0000

29d. Date signed (Month, Day, Year)

md

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1-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear JANUARY : 05 AM 2012 Johnny B. Fisher

4a. Facility Name (if not institution, give street and number) Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death CITIZENS NURSING GRACE HARFORD HAVRE HOM E 5. Social Security Number | If Under 24 Hrs. 8. Date of Birth | Hours | Min. | (Month, Day, Year) | 0 5 / 1 1 / 1 9 3 9 9. Birthplace (State or Foreign Country) Virginia 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 🔀 M 2 🗆 F 72 Director 229-52-2836 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 ☐ No Havre de Grace Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 U.S.A. 106 Bayland Drive, Apt. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ X\lo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Laboratory Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donna Ruth Parsons Marshall McKinley Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Bayland Drive, Unit6, Havre de Grace, MD Mary Ellen Fisher (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem.Garden 02/03/2012 Aberdeen, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final Onset and Death Physician/ mitta pwinch disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner FILVILLAND Gaquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due tor(or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year Month signed by the a d be detached f 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Man fer of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu 1 Yes Accident Investigation 6 Could not be 2 🗌 No Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2

To the F

complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date sid ned (Month. Dav. Year) 46 30. Name and address of person who completed cause of death litem 23a) (Type, Print) WN 31. Date filed (Month, Day, Year, State Registrar

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12-00801 Bernard W Frey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 02811

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		4a. Facility Name (if not institut			er)	4	lb. City, Town, or I	Location of D	Death	-	4c. County o		
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To the He within 24 To the Fe completel	edical			the basis of e		nd/or investigat	ion, in my opinion,	death occur	rred at the tim	ne, date and p	place, and du	ue to the cause(s)	
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		30. Name and address of person	on who com	pleted cause d	f death (Item	23a)							
		Zabiullah Ali, M.D.		nt Medical			altimore Stree	et, Baltimo	ore, MD 2	1223			
S	ate	31. Date filed (Moeth, Day Ye	9 1	32. Regis	trar's Signatu								
Regist	trar	LED 1 9 501	4 1		1 60	to Kart							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30, 2012 January Maxson Faist 4:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Rossville Rossv**i**lle Baltimore Co. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under Months Days Hours Birthplace (State or Foreign Country) Min. 215-01-4060 **Director** 1 🗙 M 2 🗆 F 91 May 13,1920 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 XNo MD **Baltimore** Dunda1k 10e. Street and Number 10f. Zin Code ms 23a or must be r ō 10g. Citizen of What Country? Funeral United States 21222 4 Midship Road cal Hygiene. 3d other than "natural", or items 23 event, the Medical Examiner mus! . Page 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items jury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry 12 Years Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Faist Lillian E. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Naomi Herold (Friend) 1224 Narcissus Avenue Rosedale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or once, 2/4/2012 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura di Funeral Servica Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of 1922 Wise Avenue Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final BONE METASTASES Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PROSTATE CANCER Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). MEDIOMIYOPATHX Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical DEMENTIA Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
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9 ☐ Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVTAW STE, STE 308, BALTIMORE MD 21701 DIMITRA MITSAN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Februari 201 a 12:15 AM George Edward Goette Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hanes HOSPI HMORE d 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Nov. 27, Days Year 1917 Months Min 1 M M 2 D F Maryland 94 214-03-5420 **Director** Usual Residence of Decedent Show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 🗆 Yes 2 🎦 No Catonsville Baltimore MD 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any njury or other traumatic event, the Medical Examiner must be 1 once. Funeral USA 21228 12 Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎽 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Aluminum Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Daisy Pearl Titchernell Robert George Goette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 331 Big Hawk; New Braunfels, Texas 78130 19a. Informant's Name/Relationship (Type, Print) Daughter Judy Goette 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 2/3/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 . Signature of Euneral Service Licensee morosv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days Phy_ician/ disease or condition resulting in death) neumonia Medical e to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed trans that initiated events resulting in death) Last and Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical 10ette, George E. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached for a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie

State Registrar (Check

only one)

29b. Signature and title of certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

02/01

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Jack Burton Gué 2012 10:25 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under **Funeral** Hours **Director** 239-30-8282 1 XM 2 □ F June 9, 1925 86 North Carolina items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD Takoma Park 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 807 Davis Ave. 20912 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö 1 Never Married 2 Married by XYes 2 ☐ No Yes, Give Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced Year or Dates. WW II Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "I Elementary/Secondary (0-12) College (1-4 or 5+) the Banker Commercial Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ t. Page 1 and 2 should be f tment of Health and Menta rtant: If item 27 is marked jury or other traumatic ev Leon Victor Gue Jenny Amelia Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Fitzpatrick / Guardian 811 Davis Ave., Takoma Park, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department of Important: If any injury or Chesapeake Crematory 01/30/2012 Beltsville, MD 21. Signature of Finer 1 - rvice Licensee Rapp Funeral and Cremation Services M00982 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequence of Exam and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the at d be detached for 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CARDIOGENIC SHOCK Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed should Were autopsy findings available prior to completion of cause of RESPIRATORY DISTRESS 24a. Was an page 2 s autopsy performed? Yes 2 No death? certificate CEREBROVASCULAR ACCIDENT 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2X No HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R143201 1.29.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar DEBRAH MILLER,

CRNP;

6001 MUNCASTER MILL RD, ROCKVILLE, MD

20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per inf g924 2-16-12 vt
State of Maryland 7 Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Day 0 Physician/ (9m spor JANUARY 2012 05:41A M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL 355 KINGSBURY WAY, WESTMINSTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** GERMANY Months Hours 1 □ M 2 🛛 F 08/02/1916 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Director 1 Yes 2 X No CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 355 KINGSBURY WAY, 21157 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🕅 Widowed 4 🗆 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) VIOLINIST MUSIC 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည **BACHARACH** ROSE WEINER WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Health a 6839 SIMPSON ROAD, GLEN ROCK, PA 17327 INA HARRISON / DAUGHTER injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/01/2012 BALTIMORE HEBREW REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each light Onset and Death Immediate Cause (Final Angelcian/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events nding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending properties as IF FEMALE 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/10 3 Probably 4 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No ဂ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural injury 5 Pending Investigation Accident within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month 29b. Signature and title of certifie vorman Date filed (Month, Day, Year) State **FEBO** Registrar

DHMH 17 Rev 7/2009

			For State Registrar	State of Marylan		artment rtificate			•	gienę Reg. No!	71117	02816
	Physici	an	1. Decedent's Name (First, Middle, Last	GREE	ENB	ER4			2. Date of De Month	ath Day	Year 2012	3. Time of Death 3:30 P M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, 7	Fown, or Loc	cation of Death			County of Death	
أعب	Examini	er	LEVINDALE HEBREW				TIMOR				N/A	
	Funeral Director		5. Social Security Number 6. Se		last birthday) 94 Yrs.		1 Year If	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 03/08	th y, Year)	9. Birth	place (State or Foreign intry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or L	ocation						10d. Inside City Limits
	Mary P-f sh fied a	ţċ	MD N/A	BA	ALTIMO	RE						1 X Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip	Code			10g. Citi	izen of What Co	intry?
	tth wil		2908 TERRY DRIVE	E, #D			209					USA
36	d within 72 hours after death with the Maryland sjene. Than "natural;" or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	.S. 13.	Was Deced If Yes, spec 1 ☐ Yes 2		anic Origin? (S Mexican, Puert Specify:	pecify Yes or No to Rican, etc.))-	14. Race - Amer Black, White Specify: WHI	, etc.
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or <	is is	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐							6 ☐Other (Spe	cify)
_	ng ftei nei		27. Manner of Death 1. ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injury at Work?		28d. Describe	how inju	ry occurred	
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	Fo the within Fo the comple	Me	29b. Signature and little of certifier			290	c. License nu	umber		29d. Da	ate signed (Mont	h, Day, Year)
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-	/		30. Name and address of person who			Print) LC	VIND	ME-H	FBREW	att	LIATRIC	CTP
5			BABATUNDE AJAN				AGNO	NENH	& BAN	Mo	ne mi	121215
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 3 2012	37. Registrar's Sign	ature	aked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ 101	partment of Health and N	Mental Hygiene	0010 00017
			- Negistiai	ertificate of Death	Reg. No	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Date	3. Time of Death 3. 7 2:22 P. M
	Medic	al .	Marlene Beatrice Grandberry	T		
1	Examin	er	4a. Facility Name (if not institution, give street and number) 190 Pittston Circle	4b. City, Town, or Location of Death Owings Mill		c. County of Death Baltimore
	Funeral		5 Social Security Number 6 Sex 7 Age (In vrs. last birthday		8, Date of Birth	g. Birthplace (State or Foreign
	Funeral Director		061-24-5448 1 □ M 2 X 78 Yrs.	Months Days Hours Min.	Apr. 30,	1933 New York
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	yland -f sho ed at	형	10a. State 10b. County 10c. City, Town or I			1 ☐ Yes 2XXNo
	r 28a notifi	Jire	MD Baltimore Owi	ngs Mills 10f. Zip Code	10g C	Citizen of What Country?
	ith th	la	190 Pittston Circle	21117		U.S.A.
	ems r	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial XX Cremation 3 Removal from State 20b. Place of Disposition A Complete C		D. 3,	Location - City or Town, State nchester, MD
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			23a, Pad/1 Enter the disease, or complications that caused the death. Do not e			Approximate
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	Medical		Immediate Cause (Final disease or condition resulting in death) A Due to (Ar as a consequence of): Sequentially list conditions.	2474/211/1		7 629
	Examiner	L	Sequentially list conditions, b. Coronary A, La	ry duegse		S 48918
	n ±	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying	1		1
	ecuted and -trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):			
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89	certifi anding use a	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1	B Ectopic pregnancy		23d. Date of delivery
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Division of Vital Records, P.O.	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
۵	pital ours a eral c		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occured at the time, date and place, a	nd due to the cause(s)	and manner as stated.
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge	vestigation, in my opinion, death occurred a	at the time, date and plac	ce, and due to the cause(s) and manner stated.
	Vithir Comp	2	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			Splet Return	D51426	Ja	nuary 31,2012
	iOV		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	1/ 4/1 -7	1208
	{		Elliot Rothschild. 4000 Old Coe	ut Rd, Pitesu.	11e, 110 Z	1200
	Sta Registr		FEB U & ZUIZ Channes J. Janes	<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:40PM Willie Carson Hubbard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Joseph Richey Baltimore . Social Security Number If Under 1 Year If Linder 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min 219-14-1696 **Director** 1 X M 2 □ F 86 2/18/1925 VA Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3620 Erdman Ave. 21213 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Trans America Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Truck Driver Truck Company 12th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carson Hubbard Mary Sue Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nannie Vaughn-Sister 101 LaRue Sq. Baltimore, MD 21225 Baltimere, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Zion Cemetery 2/3/2012 Lansdown, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Corman Records, Completed 1 ☐ Yes 2 ☐ No 3→ Probably 4 ☐ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence HOSPICO funeral Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 D Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident
3 Suicide Investigation
Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knot 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0060426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BultiMD 2120 FEB 0 3 2012 State Registrar

12-00644 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02819 Mary Elizabeth Hendrix State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 23, 2012 Medical Examiner Elizabeth 1620 hrs Mary Hendrix 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) DC 579-48-0438 79 Apr 21, 1932 1 M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State MD Prince George's Hyattsville 1 X Yes 2 No iit. Pages I and 2 should be filed within 72 hours after death with the Maryland rumment of Health and Mental Hyggene. ordant: If item 27 is marked other than "natural", or items 23s or 23s-f shory or other transmite event, the Medical Examiner mans be meithed, at once yor or other transmite event, the Medical Examiner mans be meithed, at other 123a or 25a-f envilled at v 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2022 Peabody Street 20782 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year Specify: White 1 Yes 2 X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Record Keeper FBI 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Samuel Moody Hendrix Alice Roberta Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Gary Hendrix/brother 2022 Peabody Street Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 02/02/12 Woodbine, MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Hell The MO1251 Reverly I. Heckrotte, P.A. Clarksv disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Clarksville MD 21029 Approximate Interval **Physician** Between Onset and /Medical Death a. Hypothermia complicating Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as e consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Lest ned by the attending physician and detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, tol or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ceuse of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Peripheral pulmonary emboli, right lower lobe with bilateral deep venous thrombosis Completed has been 24a Was en 24b. Were autopsy findings available autopsy prior to completion of cause of performed? page Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other: this 2 No 1 Yes 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? n 24 hours after com. Subject exposed to low environmental 1 Natural FOUND: Pending 1 Yes 2 V No Jan 23, 2012 1530 hrs temperatures 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2022 Peabody Street, Hyattsville, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 24, 2012 (Mess c 30. Name and eddress of person who completed cause of death (Item 23a) 101

DHMH 17 Rev 1/2001

State

Registrar

Ana Rubio MD.

FEB 003 2012

32. Registrar's Signature

OCME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

amen #1,per phy,g924 2-9-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26,perCNP,G924,2/3/2012 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred H. Hauf Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 217-24-6601 1 M 2 X F 82 May 16,1929 Maryland Usual Residence of Deced 28a-f shov items 23a or 28a-f shoner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director Maryland Anne Arundel <u>Pasadena</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 98 Will-O Brook Drive 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the 8 N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Sad1er Mildred Crofoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl t of Health a :: If item 27 is Franklin B. Hauf (Husband) 98 Will-O Brook Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If
any injury or
once. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 01/31/2012 Brooklyn Park, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Multi Oraa disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and I-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir မ 1 Inpatient 2 K ER/Outpatient 3 IDOA After this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide 5 Pending 1 Yes 2 No Accident Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) License number 29d. Date signed (Month, Day, Year)

3. Time of Death

9. Birthplace (State or Foreign

White

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

2× No

Year

1 Tes 2 No

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hannah Louise Hemmerly 11:07 A M February 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Home Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date or building (Month, Day,) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 Months Days Hours 140 30 6109 **Director** 95 Pennsylvania Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Essex 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2118 Tred Avon Rd. 21221 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force è 1 Never Married 2 Married Maryland 21215-0036 Yes 2 No 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RN-Nurse Health Care permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Knecht Johnson Elsie Christina Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Howard Hemmerly (Son) 209 Clinton Avenue Apt.9E Brooklyn, New York 11205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Bayview Crematory Inc. 2/3/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. m 1407 Old Fastern Avenue Essex Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Advanced End Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, heading to in mediate cause. Enter Underlying Examine day to for as a consystemay of physician and s the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Terrance 1. Billin MDMS 560/ Louh Revan Blud 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Edison Diebert Holliday Physician/ Month 1/23/2012 Year 5:30pm Medical ity Name (if not institution, give street and number)

Lake Forest Drive 4c. County of Death **Examiner** . Facility N 1256 City, Town, or Location of Dea Davidsonville Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Social Security Number 207–01–8065 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year 12/2/16 95 **Director** 1**X** M 2 □ F Yrs Usual Re "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PA Somerset Somerset 1 Yes 2 No 10e. Street and Number 2334 W. Bakersville-Edie Road 10f. Zip Code 10g. Citizen of What Country? 15501 Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or item—any injury or other traumatic. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 2 XNo Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify. White Specify: 3 ₩Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Recorder of Deeds County Be 17. Father's Name (First, Middle Last)
SCOLL HOLLIDAY 18. Methor's Name (First Middle Maiden Sumame) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1256 Lake Forest Drive, Davidsonville MD 20135 Holliday /Son Rex F. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Ardent Crematory or other place) 2/3/3012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Doda Victor P. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ardiovashular disease Examiner ler Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \(\subseteq \text{ No} \) Month Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached f conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has filled in by the funeral director, page 2 1 Yes 2 No 1 Yes 2XXNo or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Son's Home 6 Sther (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Whatural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D completely filled in Hospital Medical Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year)

FEBA

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Evaraine must be notified at acres of a pages.

Physician

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State of Mary Registrar		rtment of F ificate of			ne .no.2012	02823
1	Decedent's Name (First, Middle, Last)			2	. Date of Death		3. Time of Death
	Laura E. Julian			-	Month	Day Year	10-20 M
4	a. Facility Name (If not institution, give street end number)		4h City Town, o	Location of Death	ebruar	y 1, 201. 4c. County of Dea	
48	Future Care Northpoint		Balti				
5		In yrs. last birthday)	If Under 1 Year		. Date of Birth	9. Bir	thplace (State or Foreig
	13-52-0020 1 M 2 X F 6		Months Days	Hours Min.	(Month, Day, Y	ear) Co	cyland
	Joual Residence of Decedent	,			-5-15-	T [Fid]	yrana
1	0a. State 10b. County 10	0c. City, Town or Loca	ation				10d. Inside City Limit
3	MD	Baltimo	re			1 Yes 2 N	
1	0e. Street and Number		10f. Zip Code		10g	. Citizen of What C	ountry?
2	1046 Old Northpoint Rd.		21224			USA	
ī	1. Marital Status 12. Was Decedent Eve	er in U.S. 13. W		lispanic Origin? (Spec		14. Race - Am	erican Indian,
5 '	Armed Forces?			fispanic Origin? (Spec an, Mexican, Puerto R	ican, etc.)	Black, Whit	e, etc.
2	1 Nover Married 2 Married I ☐ Yes 2 No If Yes, Give X Year or Dates:	11	□Yes 21 No	Specify:		Specify: W	hite
	15. Decedent's Education	16a. Decede	ent's Usual Occup	pation		b. Kind of Business	/Industry
nanaldilloo	(Specify only highest grade completed)	/Give k	ind of work done O NOT use retire	during most of working	7		
	Elementary/Secondary (0-12) College (1-4or 5+)	Dis	abled			disable	3
	3rd 7. Father's Name (First, Middle, Last)		40104	18. Mother's Name			
ו מ	Albert Julian			Laura St	achoro	racki	
2		10h Mailine	Addrona (Ctron	and Number or Rural			Zin Code)
	19a. Informant's Name/Relationship (Type. Print) siste	L					
-	Joanna Freund					Mary La Oc. Location - City o	and 21224
2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposicemetery, cremit		2/4/2		altimore	
2	21. Signature/of Funeral Service Licensee		Name and Address	ess of Facility Jos onkling S	eph N. t.Balt	Zannino imore, N	Jr. FH
	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a complete compl	consequence of):	the mode of dy	ng, such as cardiac or	respiratory arres	2	Approximate Interval Between Onset and Death
Examine	Cause. (Disease or injury that initiated events	consequence of):	المادستا	^ ,			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	☐ Fetal death 3 ☐	Ectopic pregnan Other (specify)	су		23d. Date of d Month	elivery Day Year
Š		not resulting in the un-				and use contribute	
ֹן בַּ	Part II. Other significant conditions contributing to death but		derlying cause gi	ven in Part I.			to the cause of death?
ֹן הַ	Part II. Other significant conditions contributing to death but		derlying cause gi	ven in Part I.		2 No 3	Probably 4 Unknow
ompleted by	Part II. Other significant conditions contributing to death but		derlying cause gi	ven in Part I.	1 Yes	24b. Were prior to death?	Probably 4 Unknown
e Completed by	25. Was case referred to medical		derlying cause gi	ven in Part I.	1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. Were prior to death	Probably 4 Unknown
Be Completed by	25. Was case referred to medical		l or	26. Place of Death	1 Yes 24a. Was an autopsy perform 1 Yes (Check only one	24b. Were prior to death 1 1 Ye	autopsy findings availat o completion of cause of
lo Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 □ ■ Hospital: 1 □ Inpatient 27. Manner of Death 28a. Date of Injury	t 2 ☐ ER/Outpatien	t 3□ DOA O	26. Place of Death	1 Yes 24a. Was an autopsy perform 1 Yes (Check only one	24b. Were prior to death 1 1 Ye	autopsy findings availal o completion of cause of 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
To Be Completed by	25. Was case referred to medical examiner? 1 Yes Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day.)	t 2 ☐ ER/Outpatien	t 3 DOA Ot	26. Place of Death	1 Yes 24a. Was an autopsy perform 1 Yes 2. (Check only one to be some 5 Resider	24b. Were prior to death 1 1 Ye	autopsy findings availal o completion of cause of 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 28a. Date of Injury (Month, Day, Variable) 28a. Date of Injury (Month, D	t 2 ER/Outpatieni Year) 28b. Time of Injury	t 3 DOA Of 28c. Inju	26. Place of Death her: 4☐ Wursing Hon iny at rk?]Yes 2 ☐ No	1 Yes 24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider 8d. Describe how	24b. Were prior to death? 24b. Were prior to death? 1 Yes	autopsy findings availat o completion of cause of
Certification: To Be Completed by	25. Was case referred to medical examiner? 1	t 2 ER/Outpatien' Year) 28b. Time of Injury y - At home, farm, stre (Specify) my knowledge, death	t 3 DOA Of 28c. Inju Wo 1 E 28c, factory, office	26. Place of Death her: 4 Vursing Hon iry at rk? Yes 2 No 2	1 Yes 24a. Was an autopsy perform 1 Yes 2. (Check only one	24b. Were prior to death 1 1 Ye and a line of the control of the	autopsy findings availat o completion of cause of es 2 100

State Registrar Sw to

204

Parkville MD 21234

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dale filed (Month, Day, Year)

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Kim Yen 2012 8:30 a.Mn January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Arcola Nursing Center 8. Date of Birth
(Month, Day, Year)
Mar. 2, 1920 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🗓 F Cambodia Min. Hours Director 91 586-36-8503 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🖁 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Completed by Funeral 20902 permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importantt, If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b once. 901 Arcola Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kim Heuv Sok Tramuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9727 Mount Pisgah Rd. #1204 Silver Spring, MD 20903 Seng Lin Chao (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Feb. Date 01, 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State 2012 Beltsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Fune al Service Licensee M00982 X 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hypertension anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter for u in the past 12 months?

1 Yes 2 No Day Pregnant at time of death the a g Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsv performed?

1 Yes 2 XNo 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A
bleted filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 2

To the

State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certifie

3 [

Ton That Chieu, M.D. 7505 New Hampshire Ave. Suite 310, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D54486

29d. Date signed (Month, Day, Year)

JANUARY 31, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 28e, f per me g924 2-16-12 yt. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year EUGENE RAY KANE 1000pm 29 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale FRANKLIN Sauare HOSPILL Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🔀 M 2 🗆 F Hours 216-24-9189 82 6-9-1929 MARYLAND Director Usual Residence of Decedent show 10b. County 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD BALTIMORE KINGSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 Funeral 11705 KING TOP DRIVE U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced If Yes, Give Specify. giene. ner than "natural", Year or Dates. KOREA 49 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8 POLICE OFFICER BALTIMORE CITY Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CURTIS KANE RUTH SAUNDERS 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE HUTCHESON/ 11705 KING TOP DRIVE KINGSVILLE, MD 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State BEL AIR MEMORIAL 2-2-2012 BEL AIR, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Sondice Dicensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phymician/ Sepsis disease or condition resulting in death) Medical Due to (o as a consequence of): Examiner orcation monic Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Disea ARten sician and burial-trans 0101014 that initiated events रु Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 KP WED use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 3d. Date of delivery CERTIFICA 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 1 Yes 2 9 Unknown a | Linknown P.O. I s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page 2 performed? death? 1 Yes 2 No this certificate Yes 2 No or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 🔲 Natural 5 Pending -17-12 2 No Fall death. 2 Accident Investigation Unknowis within 24 hours a er deal To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office **Admitt 9. Med fcal Day Center** Location (Street and Number or Rural Route Number, Cip 2 bwn Joppa Rd. Parkville, filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 14 Houtil MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 thi Franklin Square Drive Baltimore. John Kottara Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 3. Time of Death 2:30 p_M 2. Date of Death Physician/ January Da 26 2012 KIMAIYO KWAMBAI Medical Greater Baltimore Medical Center 4b. City, Town, or Location of Death Towson Examiner 4c. County of Death Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min 595-59-136 **Director** 1 XM 2 🗆 F 37 Eldoret, 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits MD COCKEYSVILLE 1 Yes 2 1 No 10e. Street and Number ō 10g. Citizen of What Country? ems 23a or r must be r Funeral VISTA KENYA 21030 items ? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, event, the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 Married 2 No 9 þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: BLACK "natural" 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than MAMA LEAHSI Elementary/Secondary (0-12) College (1-4 or 5+) COOK 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ pe PROP Important: If item 27 is marke any injury or other traumatic JEP. and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER) BROOKRUN · SOUTH BEND. INDIANA Kache he 1118 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ELDORET, KENYA 2012 ☐ Donation 5 ☐ Other (Specify) GREENE FUNERAL SCYS PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4905 RUAD M1436 YORK 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition neumoni Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 잍 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred After. Natural 5 🔲 Pending work 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation To the Hospital or Attend within 24 hours after death To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Corriging Number Fractitionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner are stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Touson has 32. Registrar's Sig State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Day Jan 304 Donald A. Kreinbrink 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours Min Country)Wisconsin 0672671962 **Director** 352-58-0465 49 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-4 show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD **Baltimore** Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funera! 6422 Baltimore National Pike 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) IT Technology Senior Software Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JoAnn M. DeNomie Donald J. Kreinbrink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Chapel Street, Louisville, OH 44641 Randy Kreinbrink / brother 1731 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/02/2012 Glen Burnie, Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Sulphur Spring Rd. Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Days Immediate Cause (Final Physician/ JICIPAL VERDOSE WITH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): 23d. Date of the livery
Modified Day IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Hospital or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) page 2 should be detached signed by the 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by Records. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' D'rector: After this certificate 1 Yes 2 No 1 Yes 2 No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes death. 2 No the Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6422 Baltoriose National Fike, Baltonse, MO 2122. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined NOTEL within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P24065 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE, BALTIMORE, MD HOSPITAL RIAZ

Registrar

State

KREINBRINK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT C. LYNCH Month 2012 JANUARY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death MEDICAL ALTI 10 7. Age (In yrs. last birthday) If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 218-26-7547 Director 1 X M 2 🗆 F 82 1/22/1930 MARYLAND Usual Residence of Deced 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE TOWSON 1 🗌 Yes 2 💢 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21239 USA 6715 QUEENS FERRY ROAD 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2X Married 1 Yes 2 Xo If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. 3 Widowed 4 Divorced WHITECompleted 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEERING CIVIL ENGINEER YEARS other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P JOSEPH E. LYNCH MARION REED 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or are 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN S. LYNCH/WIFE 6715 QUEENS FERRY RD. TOWSON, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State METRO CREMATORY, INC. 2/3/2012 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Signature of Funeral Service Licensee MO0212 8521 LOCH RAVEN BLVD. TOWSON. MD 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-trans resulting in death) Last Physician/Medical that the death certificate be Box 68760 the nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TENSION Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available autopsy prior to completion of cause of autopsy performed? 1 Yes 2 X No ISCHEMIC death? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes after death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	ate of Maryland		rtment c tificate c		and M		jiene _{Reg. No.} 2	112	02829	
	Physicia		1. Decedent's Name (First, Middle, Last)	LOMAX					2. Date of Dear Month		Year 2012	3. Time of Death	
	Medic Examin	al	TONYA 4a. Facility Name (if not institution, give street a				n, or Location		JANUARY			8:20 PM	
	LAdiiiii		FORT WASHINGTON HOS	PITAL			WASHIN			4c. County of Death PRINCE GEORGE S Birth 9. Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. lat	st birthday) Yrs.	If Under 1 Y Months Da	ays Hours	Min.	8. Date of Birth (Month, Day, AUG. 31	Year) 1964	9. Birthp Coun WASH	lace (State or Foreign try) LNGTON, DC	
	nd now at	l h	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation					1	0d. Inside City Limits	
	Marylar 18a-f sl	Director	MD PRINCE GEOR	GE'S OXO	N HILI	,	_					1 K Yes 2 □ No	
	th the last or 2 as or 2 the no	al Di	10e. Street and Number			10f. Zip Co				10g. Citizen of	What Cour	itry?	
	eath wi	Funeral	1165 MARCY AVENUE 11. Marital Status 12. Wa	as Decedent Ever in U.S	. 13. W	207 /as Decedent	of Hispanic O	rigin? (Spe	cify Yes or No-		ce - Americ		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	1 XNever Married 2 Married 1	med Forces? □ Yes 2 X No Yes, Give ar or Dates.		Yes, specify (Hican, etc.)	Specify	ck, White, o		
15-(72 hou n "nati Aedica	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	(Give k	ent's Usual Oo ind of work do NOT use ret	ne during mo	st of worki	ng	16b. Kind of E	Business Inc	dustry	
212	within /giene. ner tha t, the N		12TH	ollege (1-4 or 5+)		EACHER	ASSIS				ERNME	TZT	
and	be filed antal Hy ced otf c even	To Be	17. Father's Name (First, Middle, Last) ROBERT LOMAX					her's Nam RBARA	e (First, Middle, I HARVE		ne)		
Maryland	should I and Me is marl		19a. Informant's Name/Relationship (Type, Prin				reet and Numl	ber or Rura	I Route Number	; City or Town,			
e, S	and 2 s Health em 27 ther tra		BRIDGETTE LOMAX/SIST		1165 lace of Dispos	_			N HILL,	MARY LA			
altimore,	age 1 aent of H		1 ★ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	val from State C6	emetery, crem RESURRE	atory or other	place)			CLINTO			
Baltii	permit. P Departm Importal any injui		21. Signature of Funeral Service Licensee	5		Name and A						L HOME, INC. ND 20785	
			23a. Part 1. En er the disease, or complication shock, or leart failur. List only one caus	ns that caused the death se on each line.								Approximate Interval Between Onset and Death	
	Pnysician/ Medical		Immediate C/ use (Final disease or c of ition resulting in death)	CARDIORESI Due to (or as a consequ		RY ARRI	EST				-	Office and Death	
	Examiner		Sequentially list conditions, b.	HYPERTENS									
	be sit	Examiner	cause (Disease or iinjury	онь to (ог ав а полвеци	lenow off:								
	execute an and ial-tran	Еха	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					<u> </u>			
90	ate be executed physician and the burial-transit	dical	d										
687	certifica nding p use as	m/Me	IF FEMALE: 23c. If 23c. If	yes, outcome of pregna	ncy	Ectonic area	mancy			23d. D	ate of deliv	ery	
P.O. Box 687	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months?	Pregnant at time of c		Other (speci					lonth	Day Year	
P.O.	that th gned by e detac	by Ph	Part II. Other significant conditions contribu	ting to death but not res	ulting in the u	nderlying cau	se given in Pa	rt I.				he cause of death?	
rds,	equires een sig nould b	eted							1 🗀 '			bably 4 Unknown	
eco	The law i cate has t page 2 s	Completed							autop perfo	osy	prior to co death? 1 Yes	mpletion of cause of	
Tal H	cian: Ti ertificat ector, pa	Be C	25. Was case referred to medical examiner?	al:			6. Place of De	eath (Chec		2 23 110	-		
of Vi	Physic r this o	မူ	1 Kres 2 LI No	1 ∐ Inpatient 2 ☐ Ba. Date of injury	28b. Time of		Injury at	Nursing H	ome 5 Resid			y)	
ouo	ending eath. or: Afte he fune	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury	М	work? 1 🗌 Yes 2	□ No					
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		4 Homicide determined	e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, of	fice		28f. Location (S City or Tow		ber or Rura	l Route Number,	
	e Hospital 24 hours e Funeral I leted filled	Medical	29a. Certifier 1 X Certifying Physician: (Check 2 Medical Examiner: O only one) 3 Certifying Nurse Prac	n the basis of examination	n and/or inves	tigation, in my	opinion, death	occurred a	t the time, date a	ind place, and d	lue to the ca	ause(s) and manner stated	
_	To the within To the comp	2	29b. Signature and title of certifier		<u>, , , , , , , , , , , , , , , , , , , </u>	29c. Li	cense number			29d. Date sign			
			30. Name and address of person who comple	<u>v</u>	23a) (Tvne 1)-002	408'/		01	(311		
	21		SANTIAGO MORAO JR.	MD. 6357 OX	CONHILI		OXONHI	LL, N	1ARYLAND	20745			
	Sta Registr		31. FEB 0 3 2012 Dener	32. Regilitrar's Sir na	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Bradley Russell L		1- For State	e of Maryland	/ Depar		lealth ar			giene	21	112 0	283
Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)		modito of E			2	2. Date of Death	g. No.	3. Time of D	Death
Medical Examin		Bradley	Russell	Lon					Month January 29		1853 h	
		4a. Facility Name (if not institution, of Howard County General)	1	City, Town, o Columbia	r Location of	Death		4c. County of Howard	Death	
Funeral		Social Security Number 6.	Sex 7. Ag	je (In yrs. las	t birthday)	If Under 1 Yea	ar If Under	24Hrs.	8. Date of Birt		9. Birthplace (State	e or
Director			XXM 2 F	49	Yrs.	Months Day	ys Hours	Min.	11-06-	-1962	Foreign Country) MD)
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c City T	own or Location						10d. Inside	City Limits
. ₹	5		ward	loo. old, 1	our or Location		E11:	icot	t City		1 Yes	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho transmatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	D 1		1	Of. Zip Code	2104:	2	10	g. Citizen of Wha	-	
ith th	冒	4583 Roundhill	12. Was Decedent	Ever in U.S.	13 Was D	ecedent of Hi			cify Yes or No-		States American Indian, B	lack
eath v item		1 X Never Married 2 Marri	ed Armed Forces?	?		specify Cuba				White,		idor,
fter d		3 Widowed 4 Divorce	ed If Yes, Give Year	X No	1 🗀 Y6	s 2XX No	specify:			Specify:	White	•
ours a ntura	ē P	15. Decedent's Education (Specify	only highest grade con	npleted) 1	6a. Decedent's					16b. Kind of Busi	iness/Industry	
72 hc	활	Elementary/Secondary (0-12)	College (1-4 or	5+)	during most	of working life	e. DO NOT us	se retire	d)			
5-0036 lled within 72 Hygiene I other than "	Completed		1			Techni				Electr	onics	
15-C		17. Father's Name (First, Middle, La	•							aiden Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than marked other than	8	Charles Russell 19a. Informant's Name/Relationship	Long		10h Mailing A	dross (Stra				se Smith	State, Zip Code)	
MD 2 d 2 shou lith and M	۵[Carol S. Long -				•					MD 21043	
e, MC 1 and 2 sl Health ar item 27	ł	20a. Method of Disposition			ce of Dispositio	n (Name of ce			Date		City or Town, State	
S & E S		1 Burial 2 X Cremation		ate	ematory or other			02 <u>-</u> 0	1_2012	Clan D	ummin MD	,
Baltimo permit. Page Department Important: injury or ott	ŀ	4 Donation 5 Other Speci 21. Signature of Funeral Service Lice		ALL	antic Ci	e and Addres	s of Facility	Gary	I. Kai	ifman Fii	urnie, MD neral Hom	e at
Dep Dep III		Mark &	Sirlan	w							e, MD 210	
Physician		23a. Part I. Enter the disease, or con failure. List only one cause on		the death. D	o not enter the r	node of dying	, such as care	diac or r	espiratory arre	st, shock, or hear	t Approxima Between 0	
/Medical	- [Immediate Cause (Final disease	aAlcohol an		cotic I	itoxica	ation				De	
. A		or condition resulting in death)	Due to (or as a conse	equence of):							Ì	
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of);	_						-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):								
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D, be exessician sician s	Physician/Medical	▼ UNPENDED	AMENDED 23a	,27,28	a-f,per	me,g9	24 2-7	-12	Sm			
Box 68760, c death certificate be the attending physical dor use as the buried for use a	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregna	ncy 2 Fetal	death 3	Ectopic p	reanana	:v	23d. Date of de Month	•	Year
OX 6	ᇋ	past 12 months?	4 Pregnant at	time of deatl		(Specify)			,		24,	
he deat	֓֡֞֞֞֟֞֟֞֟֞֟֞֟֞֟	1 Yes 2 No 9 Unknown	9 Unknown		W		1011 8-1		OO - Did tol	1		1- 11-0
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of Vital Records, ag Physician: The law required the transfer of the transfer	Completed								autops perform 1 Yes 2	ned? dea	or to completion of dath? ✓ Yes 2	No
Vital Reorgistan: The his certificate director, page	8 8	25. Was case referred to medical examiner?				26.Place	e of Death (C	heck on				
hysici rthis o		1 ✓ Yes 2 No			R/Outpatient 3						Other:	
C# 141		27. Manner of Death 1 Natural 5 Pending		ear)	8b. Time of Injur		ıryat Work? Yes 2. █ N	111	3d. Describe ho nknown	ow injury occurred	i	
** # 9 # ×	Certification:	2 Accident Investigate 3 Suicide 6 X Could not	28e. Place of In	jury - At hom	e, farm, street, f			28	Sf. Location (St	reet and Number	or Rural Route Num	nber, City
6 - 2 >		4 Homicide determine 29a. Certifier 1 Certifier Physics	(Opecany)		i-famil			C	olumbia	Md.		
Divis To the Hospital or A within 24 hours after with Puneral Director Completely filled in b	Medical	(Check only	Iclan: To the best of my er:On the basis of examination and manner stated.									
E > E 8	\$	29b. Signature and title of certifier	direction stated.			29c. Licens	se number			29d. Date signed	(Month, Day, Year))
		Carol	Halla	v	-	O.C.	M.E.			January 30,	2012	
3 Olper		30. Name and address of person wh Carol Allan, MD Assis	o completed cause of d tant Medical Exan		-	ore Street	Baltimore	e MD	21223			
Sta	te	31. Date filed (Month, Day, Year)		r's Signature			, Danimole	C, IVID				
Registr	-	FFB 0 3 2012	K A		Mad							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	Sta	te of Mary		artment of F		Mental Hy	21	112	02831
			Registrar 1. Decedent's Name (First, Midd	lle, Last)			Tincate of L	Jean	2. Date of De	Reg. No	116	3. Time of Death
	Physicia Medic		John Joseph	Liberti	ni, Sr.				Janaı	ury ^D 30,	20 ° 2	6:20P M
	Examin	er	4a. Facility Name (if not institution Oakcrest Care		d number)			Location of Death	1	4c. Coun	ty of Death Balto	
	Funeral Director		5. Social Security Number 218-03-8011	6. Sex 1 X M 2	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth 2 2 1919		place (State or Foreign try)
	3		Usual Residence of Decedent						Julie A	22,1717	Pla	ryrand
	ryland -fsho iedat	ctor	10a. State 10b. Count	_	10	c. City, Town or Lo					1	0d. Inside City Limits
	the Maryland or 28a-f show e notified at	Dire	Md. B	alto.			Parkvi	lle		10- Cilinon -	6 \A/I- =4 O=	1 Yes 2 X No
	s 23a o	Funeral Director	8820 Walther B	lvd. Ap	ot. 4213	3	2123	34		10g. Citizen o	USA	itry ?
90036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorce	Arme arried 1 If Yes d Year	Decedent Ever ed Forces? Yes 2 X No s, Give X or Dates.		Was Decedent of Hi f Yes, specify Cuba 1 Yes 2 No		pecify Yes or No Rican, etc.)	14. Ra Bl Specia	ace - Americ ack, White, o fy: Wh	
altimore, Maryland 21215-0036	within 72 ho giene. er than "n al , the Medi c	Completed	15. Deced (Specify only high Elementary/Seconday (0-12) 12th	-	ge (1-4 or 5+)	(Give life. D	dent's Usual Occupa kind of work done of O NOT use retired) tsman	ation during most of wor	king	16b. Kind of Bethle		
yland	ld be filed a Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Michele Libert					18. Mother's Nar Mary L	ne (First, Middle, ibertini		ne)	
Mar	2 shou th and ?7 is m traum		19a. Informant's Name/Relation			1	ng Address (Street a					
<u>ē</u>	1 and f Heali item 2 other		John J. Libert 20a. Method of Disposition		2	20b. Place of Dispo			Date Elli	20c. Location		d. 21043
imo	Page ment o ant; If ury or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		from State	cemetery, crer St. Jose	natory or other place	· 1		Fuller	,	
On Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee		22	Name and Addres	ss of Facility Sch	nimunek	Funeral	l Home	, Inc.
27			23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications only one cause of	that caused the	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
13	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	Rex	ral for	uluve	alu	2		У	Onset and Defith
-	Examiner		and a dealing	Du	e to (or as a cor	nsequence of):	Done	e ful	100-		,	100.035
~ ~		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Du	e to (or as a cor	istiquence oi).	1 10 100	100-0			1	1000521D
19	be executed sician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	e to (or as a cor	asete	>					1000521D
30/2	te be exe tysician te burial	dical	Totaling in dealing 2201	d								•
1/3	tificate ng phys as the	Med	IF FEMALE:									-000
, Box 6	requires that the death certificate be executed seen signed by the attending physician and inould be detached for use as the burial-transi	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 4 0	, outcome of pr Live Birth 2 Pregnant at time Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	У			ate of delive	ry Day Year
P.04	w requires that the s been signed by the s should be detach	by P	Part II. Other significant condit	ons contributing	to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use cor	tribute to the	e cause of death?
ecords,	equires een sig	ted	- Yenex (intent	√ >				1 🗆	Yes 2 No	3 ☐ Prob	ably 4 🗆 Unknown
300	has by	Completed	dysph	ayer					24a. Was auto	psv	Were autop prior to con death?	sy findings available npletion of cause of
Om.	sician; The law is certificate has birector, page 2 s	Be Co	25. Was case referred to medical	AC .			26 Dia	ace of Death (Chec	1 Tes	2 No	1 Yes	2 🗆 No
Vital	hysicia nis cert direct	10 B	examiner? 1 Yes 2 No	Hospital:	1 Inpatient	2 ER/Outpatier	Othe			dence 6 🗆 Otl	ner (Specify)	
jor	ling PI ∩. Affer t∤ funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ng (Date of injury Month, Day, Yea	28b. Time of injury	28c. Injury work?	at ?		now injury occur		
VISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completed filled in by the funeral director, to the funeral director.	Certificate:	2 Accident Invest 3 Suicide 6 Coulc 4 Homicide detern	28e. P	lace of Injury - a	At home, farm, stre		Yes 2 No	28f. Location (S		ber or Rural i	Route Number,
	Hospital 44 hours a Funeral C	Medical (Check 2 L Medical	Examiner: On the	e basis of examir	nation and/or invest	ccured at the time,	n death occurred a	t the time date s	and place and de	in to the cour	ra(a) and manner stated
	Fo the vithin 2 the comple		only one) 3 Certifyin 29b. Signature and title of certifie	g Nurse Praction	ner: To the best	of my knowledge, o	eath occurred at the	time, date and pla	ce, and due to th	e cause(s) and m	nanner as sta	ted.
			20 Name and address of	1	DWSO		D003	50972		1/31	301	<u>}</u>
6	/		30. Name and address of person	K. Czw	cause of death		(10t) (380) (360)	w) ther	Blvd	Renki	rille	mD
	State		FEB 0 3 2012	Renewa 3	2. Redistrar's 9	gnature		, , , , , ,				
DU	Registra		1110 - 0010	- Constitution								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Day}2012 Year February 4:45A. Corinne V. Lookenbill Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oakcrest Care Center Parkville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Hours Days West Virginia 87 Director 235-32-9142 12-28-1924 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Md. Harford Jarrettsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2316 Birmingham Court 21084 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: "natural" 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Veteran's Elementary/Seconday (0-12) College (1-4 or 5+) 12th Personnel Specialist Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Villers Roxie May Slonaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn L. Glos 2316 Birmingham Court Jarrettsville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 2-4-2012 Balto.Md. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road Nottingham, Md. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ spiration disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) /sician a Physician/Medical attending phys for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day 5 Other (specify) Month Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**X** No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' Accident 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director; A

completed filled in by the f Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year)

State Registrar 8800 Walther Blad, Parkville MD 21014

leted cause of death (Item 23a) (Type, Print)

1/20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep State of Maryland / Dep Ce	artment of Health and N rtificate of Death	, ,	ene g. No. 2012 02833		
	Physicia Medic		Decedent's Name (First, Middle, Last) JOANNA LATORRE		2. Date of Death			
*	Examin		4a. Facility Name (if not institution, give street and number) GILCHRIST HOSPICE	4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $220-24-6776 \\ \text{Usual Residence of Decedent} \\ 1 \square \text{ M } 2\ \text{X} \text{ F} \\ 85 \\ \text{Yrs.} \\$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y DECEMBER			
	faryland 3a-f show iffied at	Director	10a. State 10b. County 10c. City, Town or Lo	ocation CTINGHAM		10d. Inside City Limits 1 ☐ Yes 2 🔀 No		
	with the N 23a or 20 ust be no	Funeral Dir	10e. Street and Number 34 WHIPS LANE	10f. Zip Code 21236	10	g. Citizen of What Country?		
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 😾 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE		
Maryland 21215-0036	within 72 hou giene. er than "nat th- Medica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work IO NOT use retired) HOMEMAKER	ing 1	6b. Kind of Business/Industry HOME		
yland;	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) R. ALBERT GUGLIUZZA	1	e (First, Middle, Ma PHINE SAB			
, Man	nd 2 shoul saith and I n 27 is ma er trauma	i i	1	ng Address (Street and Number or Run OBIN LYNNE COURT		ity or Town, State, Zip Code) LL, MD. 21128		
Baltimore,	Page 1 ar nent of He ant: If iten ıry or oth		20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Dispocemetery, creation and comparison of the comparison o	matory or other place)		Oc. Location - City or Town, State BALTO • MD •		
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility SCI 9705 BELAIR ROAD		UNERAL HOME, INC. AM,MD. 21236		
1	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death		
	Examiner	Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):					
0	cate be executed physician and s the burial-transit	edical Exan	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
P.O. Box 68760	death certifi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Pregnant at time of death 5 ☐	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year		
ls, P.O	requires that the despeen signed by the schoold be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
Division of Vital Records,	the Hospital or Attending Physician: The law requires that the Lhin 24 hours after death. the Funeral Director: After this certificate has been signed by the mpletely filled in by the funeral director, page 2 should be detach	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 \sum Yes 2 \sum No		
f Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o		k only one)	ce 6 X Other (Specify) HOSPICE		
ision o	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, str	work? M 1 □ Yes 2 □ No	28f. Location (Stree	et and Number or Rural Route Number,		
Σ	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in b	edical C	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inves	occurred at the time, date and place, a	nd due to the cause	e(s) and manner as stated.		
<u>.</u>	To the P within 24 To the F complet	Me	only one) Certifying Nurse Practitioner: To the best of my knowledge 29b. Sgnature and title of certifier	death occurred at the time, date and place 29c. License number	ace, and due to the c	cause(s) and manner as stated. d. Date signed (Month, Day, Year)		
			30. Name and address of person who completed cause of death (Item 23a) (Type, I	10071787	7 111	-30-12 ms 21204		
	Stat		Philip Sha Leen; 670(N, Chales: 31. Date filed (Month, Day, Year) 32. Registrar's Agnaty FEB 0 3 2012	5017. ≥wite 4105	i Balti	mere, My 21204		
	Registra	r	LEN A D CAIL CHANNED NO MANAGE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02834 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:05 P M February 1, 2012 William Η. Lovenstein /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie North Arundel Health & Rehab. 8. Date of Birth (Month, Day, Apr. 16, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☑M 2 ☐ F 1932 79 Director 216-28-7244 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene. and it if them 27 Is marked other than "natural", or items 23a or 28a-f shoung to other traumatic event, it a Medical Exprains must be notified at 1 ☐ Yes 2 ☑ No Directo Pasadena Anne Arundel Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 Funeral 181 Southwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify. þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Electronic Technician N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Kuh1 2 Lovenstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4204 Jefferson Avenue Sykesville, MD 21784 Michael A. Taylor (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/08/2012 | Glen Burnie, Maryland Glen Haven Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Ulim 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Year Month Day 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) Injury 5 Pending investigation 1 X Natural n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

9

OCHMEY 31. Data fled (Month, Day, Year) FEB 0 3 2012 State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-40251

HOSPITAL DRIVE

SLUTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ PM Renee Rosa Lowder 701 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/AMOYE iland enera 9. Birthplace (State or Foreign If Under 1 8 Date of Birth last birthday, Age (I Funeral Months 0176671958 Maryland 1 □ M 2 🔀 F 54 220-74-9353 **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County Director 1 XYes 2 No N/ABaltimore MD 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A 21217 2017 Burt St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S ural", or iten I Examiner r 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Kenee COUde! Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) GNA/CNA **GBMC** 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joanna Bias Frederick Yurborough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2402 Marbourne Ave. Apt 3B, Balto., MD21230 Stacy Bias(son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 02/03/12 Baltimore, MD 4 Donation 5 Other (Specify) King Park Cem. ²² Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave., Signature of Euneral Service License Funeral Home Baltimore, M MD21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Elementially list conditions: Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Q that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Furnis certificate has been signed by the attending physicial funeral Director. After this certificate has been signed by the attending physicial process. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a ld be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 1 Yes Records, been sign Completed 24b Were autopsy findings available prior to completion of cause of 24a Was an autopsy this certificate has ral director, page 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2 Veilla person who completed cause of death (Item 23a) (Type,

State Registrar 31. Date filed (Month, Day, FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lindsay Brian Martin February 2012 0806 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Gilchrist Center If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Apr 8 1 🕅 M 2 🗆 F California Director 1954 523-78-0038 57 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 7211 Dockside Lane 21045 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)
Business Development 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Energy xecutive Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) Louis Martin Betty Pullen 19a. Informant's Name/Relationship (Type, Print)
Tuula McLaney/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7211 Dockside Lane Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, Important: If injury or 4 Donation 5 Other (Specify) Final Journey Crematory 02/03/12 Woodbine, MD 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LARGE CELL LYMPHOMA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Mo*n*th Pregnant at time of death Day Year signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 🗌 Yes Hospital or Attending Physician: Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifi D64395 FEBRUARY 1, 2012

Registrar

10 V

DHMH 17 Rev 7/2009

State

6336

32. Registrar's Signature

CEDAR LANE

COLUMBIA, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO

31. Date filed (Month, Day, Year)

FEB 0 3 2012

12-00799 Tyran Myles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

yraii wyies			ificate of Death	ygichic	2012	7 0793
		Registrar 1. Decedent's Name (First, Middle,Last)	ncate of Death	Reg. N 2. Date of Death	lo.	3. Time of Death
Physicia ledical Exami	4117	Tyran Myles		Month Day January 27, 2	y Year	1710 hrs
leuicai Exami	IIGI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
1		2703 East Mura Street	Baltimore	·	N/A	
				Data of Pirth (M	M/DD/YYYY) 9. Birth	anloss /State or
Funeral Director		240 06 6705	Months Days Hours Min	_ `	1 Foreign	n `
Director		219-86-6705 1 M 2 F	17 Yrs.	8/22/19	964 Cou	intry) MD
*		Usual Residence of Decedent				404
y any			own or Location			10d. Inside City Limits
sho sho	5	MD N/A Balt	cimore			1 Yes 2 No
Aaryland 28a-f show I at once	ector	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Coun	try?
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. not: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once	<u>a</u>	11. Marital Status 12. Was Decedent Ever in U.S.			14. Race - Americ	an Indian, Black,
item net b	uneral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
fer d	щ	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify: Bla	ck
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ToB	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or I	Rural Route Number.	City or Town, State.	Zip Code)
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and 2		20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery,	Date 20d	c. Location - City or 1	Fown, State
Ore Ses 1 Of H	- [1 Burial 2 Cremation 3 Removal from State	ematory or other place) Carmel Cemt. 2/4	1/2012 Ba	altimore	MD
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Administ		or condition resulting in death) Due to (or as a consequence of):				
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ViS or A or A Direc	읡	Suicide Could not be	ne, farm, street, factory, office building, etc.	28f. Location (Street or Town, State)		al Route Number, City
pltal Ours grilled	Certification:	4 Homicide determined (Specify)		, 5.5.67		
E Hos 24 h		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge				
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directur: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated.	/or investigation, in my opinion, death occurred a	at the time, date and p	place, and due to the	cause(s)
F S H S	ž	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mon	th, Day, Year)
	ŀ	VM 17	O.C.M.E.	Ja	nuary 28, 2012	
(0)	ŀ	30. Name and address of person who completed cause of death (Item 2)	<u>I</u> 3a)	1		-
131			900 W. Baltimore Street, Baltimore	, MD 21223		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- A Communication			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month WALTERE MICHALSKI Physician 0816 February 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 16-20-4648 84 Yrs. **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at MARYLAND NUT 1 Yes 2 No Director TIMORR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.
Int; If Item 27 is marked other than "natural", or Items 23a or 7008 Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No þ Specify: WhiTe 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) CONTRACTING 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be 105 BENJAMIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, BARANOWSKI Joseph 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of important; if it any injury or conce. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility

W. DA B. Bows M. Ave 13 Alt in

23a, art 1 Inter the disease, or complise ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only our cause on each line. HOTNACKI TUNDENI Ave BALTIMORE, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live birth 2 - Fetal death 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of within 24 hours after death. To the Funeral Director: After 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DO076999 tebruary 01 2012

Registrar

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4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician/ Medical Examiner **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Please Type or P				•	_	ole.
1 - State of I		epartment of F Certificate of L			ene eg. No. 20	12 02839
1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
N L C K 4a. Facility Name (if not institution, give street and number		ENDEL MAGY	Location of Death	01^{Month} 30	201	
Tate Hospice House			cum Heig	ghts	4c. County of Anne	Arundel
5. Social Security Number 6. Sex 1 M 2 D F 7.	Age (In yrs. last birtho	day) If Under 1 Year Months Days		8. Date of Birth	(ear)1 2	Birthplace (State or Foreign Country)
Usual Residence of Decedent			-	12 31 1	913	MD
10a. State 10b. County MD Anne Arundel	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2.™ No
MD Anne Arundel 10e. Street and Number	Pasad	10f. Zip Code		10	ng. Citizen of Wha	
7662 Pine Haven Drive			21122		U.S	.A.
11. Marital Status 12. Was Deceder Armed Force 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2	t Ever in U.S. ? ▼ No	 Was Decedent of His If Yes, specify Cuba 	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)		American Indian, White, etc.
3 ★ Widowed 4 □ Divorced If Yes, Give Year or Dates	Z 1/10	1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
15. Decedent's Education (Specify only highest grade completed)	1 (Decedent's Usual Occup Give kind of work done of	ation luring most of working	g 1	6b. Kind of Busir	ness Industry
Elementary/Seconday (0-12) College (1-4 c	r 5+)	ife. DO NOT use retired) echanical	Engineer	.	Aerona	utical
17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	aiden Surname)	
Wendel 19a. Informant's Name/Relationship (Type, Print)	Magyar	Mailing Address (Street a	Barbara			- 7:- O-d-\
Carol Erat - Daughter		17 Linthi		Linthi		
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from Sta	20b. Place of I cemetery,	Disposition (Name of crematory or other plac	e) Da	ate 2	0c. Location - Ci	ty or Town, State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Marcal Service Licensee	New Ca	thedral (-		
21. Organistic Organistic Library		169 Rivi	GJ	Gonce e Pas	Funera adena,	1 Home, PA MD 21122
23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do no	1 .	g, such as cardiac or	// /	t,	Approximate Interval Between
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in the past 12 months?	2 Fetal death at time of death	3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of Month	*
g □ Unknown 9 □ Unknown						
Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba		te to the cause of death?
				24a. Was an		re autopsy findings available
				autopsy _ perform	prio ed2 dea	r to completion of cause of
25. Was case referred to medical examiner?			ce of Death (Check c		A NOT	1163 2 1110
1 ☐ Inpa 27. Manner of Death 28a. Date of in	tient 2 ER/Outp	ne of 28c, Injury	4 U Nursing Hom	e 5 Residen		Specify) Hospice
1 Natural 5 Pending (Month, D	<i>ay, Year)</i> inju	ury works			mary occurred	
4 Homicide determined 28e. Place of I	ijury - At home, farm tc. <i>(Specify)</i>	n, street, factory, office	. 28	If. Location (Stre	et and Number o State)	r Rural Route Number,
29a. Certifier 1 Certifying Physician: To the best	of my knowledge, de	eath occured at the time,	date and place, and	due to the cause	(s) and manner a	s stated.
(Check Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or in e best of my knowled	ige, death occurred at the	time, date and place,	ne time, date and and due to the ca	place, and due to ause(s) and manne	the cause(s) and manner stated. er as stated.
29b. Signature and title of certifier			7505	5	d. Date signed (M	7 30, 2012
		pe, Print)	Glen Bu	mie,	MD. 2	1061
31. Date filed (Logth Day 2012 Ages)	rar's rignatur	Ked				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MIRKIN SZAINDLA Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE COURTLAND GARDENS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Hours 1 □ M 2 💢 F 65725/1925 POLAND 86 **Director** 213-58-3710 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1x Yes 2 ☐ No BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 3601 CLARKS LANE, #703 21215 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 pe UNKNOWN ROTENSTEIN MARIA 1 and 2 should be Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 BARNSTABLE COURT, OWINGS MILLS, MD ADOLFO MIRKIN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or or once. 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/02/2012 RANDALLSTOWN, MD BETH EL MEMORIAL PK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mais Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner mon/4 nsen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine consequence of Szainel Cause (Disease or iinjury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) 1 Yes 2 g Unknown g D Unknown the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗀 No this certificate 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 🗌 Yes 2 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Duath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natura. 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) FEB 0 3 2012

30. Name and address of

Registrar's Signatur

person who completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month JACK L. **MEYER** 11:55 2012 auva Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4730 ATRIUM COURT, #175 OWINGS MILLS BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □**X**M 2 □ F 042-07-6228 Director 91 CTUsual Residence of Decedent 28a-f shov 10a, State 10b. Count with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE OWINGS MILLS 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? injury or other traumatic event, the Medical Examiner must be 23a Funeral 4730 ATRIUM COURT, #175 USA items 2 Page 1 and 2 should be filed within 72 hours after death vannt of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) FOOD & DRUG Elementary/Seconday (0-12) College (1-4 or 5+) 5+ CHEMIST ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 MAX MEYER RACHEL RITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENA WEKER / DAUGHTER 1229 KNOX ROAD WYNNEWOOD, PA 19096 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM.GARDENS 02/02/2012 OLNEY, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myecardial disease or condition hour Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events Due to (or a consequence of): as the burial-transit Advanced resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 1 🗌 Yes 2 🗆 No the Hospital or Attending Physician: thin 24 hours are death. the Funeral Director After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 140 Other: ုင 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 4 Nursing Home . Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 hild 4000

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 M Jan. 31 6:10 A Ruth N. McCardell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Towson Gilchrist Hospice Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours Months 1 🗆 M 2 🗓 F **Director** 225-48-1580
Usual Residence of Decede 74 Yrs April 6,1937 VA ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10c. City, Town or Location 10d, Inside City Limits 10a. State death with the Maryland Director Edgemere 1 Yes 2 XNo MD Baltimore 10f, Zip Code 109, Citizen of What Country? 10e, Street and Number Funeral United States 21219 3001 Delmar Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the Own Home Homemaker 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ eq pinous Erie Eva Tabor Paris Milton Waddell traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health a Mr. Emmett B. McCardell Edgemere, Maryland 3001 Delmar Avenue other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Department of Important: If it any injury or conce. 1 Burial 2 X Cremation 3 Removal from State 2/4/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland <u> Hilltop Service Corp.</u> 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk. Maryland Part 1. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): vajoular ducase **Examiner** Sequentially list conditions, if any library to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 2No 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? 2/1 No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) ple 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

24 hours a Funeral C

within 24 hou

To the Fune

completely fi

Medical

State Registrar

29a, Certifier

(Check

only one 29b. Signature

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and title of certifie

(ES 5701

ss of person who completed cause of death (Item 23a) (Type, Print)

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Noimel

12-00824 Brenda March

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02843 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ficate o	f Death		F	Reg. No.		
Physic			dle,Last)					2. Date of De	ath	3. Time of Death	
Medical Exam	iner	Brenda		M			rch	Month January		U824 Nrs	
		4a. Facility Name (if not institution Carroll Hospital Center		er)		4b. City, Town, or Westminst		Death	4c. County of Carroll	f Death	
		5. Social Security Number		Age (In yrs. last	high days)	If Under 1 Yea		irth(MM/DD/YYYY)	O Birtheless (Ctate as		
Funeral Director				Age (in yrs. iast	Dirtinday)	Months Day		Min.	III (IMM/DD/TTTT)	Foreign	
		216-74-5667	1 M 2 XF	54	Yr	S.		08-20	-1957	Country) MD	
Áu		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Local	tion				10d. Inside City Limits	
д В № 38	١.	MD Ca	rroll			inster				1 Yes 2XXNo	
Maryland 28a-f show any 1 at once.	cto	10e. Street and Number			WC3 CIII.	10f. Zip Code			10g. Citizen of Wha	at Country?	
e Ma or 28	Director	2265 5 1					_				
1215-0036 do filed within 72 hours after death with the Maryland fental Hygiene, are mattered other than "natural", or items 23a or 28a-f aho event, the Medical Examiner must be notified at once.	12	3365 Sykesvil	Le Koad 12. Was Decede	nt Ever in U.S.	13. Wa	2115 as Decedent of Hi		? (Specify Yes or N	United St	ates American Indian, Black,	
eath v item	Funeral	1 Never Married 2 X N	Armed Force					uerto Rican, etc.)	White,		
fter d	Ĭ,	3 Widowed 4 Div	vorced If Yes, Give Year	∠ LXI No	1 🗆	Yes 2 X No	specify:		Specify:	White	
ours a atura	d by	15. Decedent's Education (Spe	or Dates: ecify only highest grade co	ompleted) 16		nt's Usual Occupa			16b. Kind of Bus		
72 h 72 h E	Completed	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	during m	nost of working life	e. DO NOT us	se retired)	1		
5-003(led within Tygiene.	Ę		2		Recep	ptionist			Hair Sa	11on	
5-003	ပိ	17. Father's Name (First, Middle						Name (First, Middle,			
2121 uld be fil Mental J marked	Be	James H. 19a. Informant's Name/Relations	Peltzer, Ji		101 11 11			elyn M.			
MD 21215-0036 d 2 should be filed within 7 this and Mental Hygien a 27 is marked other than umatic event, the Medica	10							er or Rural Route Nu			
e, MD 2 l and 2 shou Health and N litem 27 is n		Amy M. Eckert 20a. Method of Disposition	(daughter)			ria r KSIIIa:		Hampstead Date	•	Cify or Town, State	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. The strict of Health and Mental Hygiene "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once		1 XX Burial 2 Cremation	n 3 Removal from S		matory or ot		,	54.0	255. 2552	ony or rount, out to	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other S		Eve	rgreei	n Mem. G	ar.	2-1-2012			
Bal permi Depar Impo		21. Signature of Funeral Service		. 1.	- 1				NERAL HOM		
		23a. Part I. Enter the disease, or	J. Wayne (od the death. Do	ng L.	he mode of dving	sterst	OWN Kd . K	elstersto	own, MD 21136 Approximate Interval	
	Physician Medical Medical Symptoper Medical										
£xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con		ı sep	SIS				Death	
		Sequentially list conditions,	b								
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):					···		
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of);							
xecuted n and ransit	Ĕ	events resulting in death) Last	d.								
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760, cate be physici	Mec	IF FEMALE:	23c. If yes, outcome	ome of pregnar	ncy				23d. Date of d	lelivery	
687 certific iding	ian/	23b. Was decedent pregnant in the past 12 months?	I FIA6 DILIII	at time of death		etal death 3	Ectopic pr	regnancy	Month	Day Year	
Box 687 e death certificate attending of for use as t	Physician/	1 Yes 2 No 9		at time of death	5 Ot	ther (Specify)	-	A STATE OF THE STA			
by the ached	F.	Part II. Other significant condit		ath but not resu	Iting in the u	underlying cause	given in Part I	I. 23e. Did t	obacco use contrib	ute to the cause of death?	
P.O.	b o							1 Ye	es 2 🗸 No 3	Probably 4 Unknown	
Division of Vital Records, ral or Attending Physician: The law requirers after dearch. In Director: After this certificate has been side in by the funeral director, page 2 should be	Completed							24a. Was		ere autopsy findings available	
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tal Resident The	ပိ	25. Was case referred to medica				26 Place	of Dooth (Ch	1 Yes	2 No 1	✓ Yes 2 No	
Vital Recysician: The his certificate director, page	o Be	examiner?	11	ient 2 🗸 EF	VOutpatient		Othor -	lursing Home 5	Residence 6	Other:	
n of \ding Phy i After th	-	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, Day		Bb. Time of I		ry at Work?		how injury occurred		
on endin ath. or: A	ţi	1 X Natural 5 Pen	ding	, raar)		1 🔲	Yes 2 No	0			
Visior or Attend ter death irector:	fica		stigation 28e. Place of	Injury - At home	e, farm, stree	et, factory, office b	ouilding, etc.			or Rural Route Number, City	
Divi	Certification:		rmined (Specify)					or Town,	State)		
E Hospital 124 hours a Funeral I etely filled			hysician: To the best of								
To the Hos within 24 h To the Fur completely	Medical	7	miner: On the basis of ex and manner stated		prinvestigat	tion, in my opinior	n, death occur	rred at the time, date	and place, and du	e to the cause(s)	
	Σ	29b. Signature and title of certific	er .	//		29c. Licens				(Month, Day, Year)	
(4)		(a/11	111	///	(O.C.	M.E.		January 29,	2012	
		30. Name and address of person		. /	,						
			Assistant Medical E		900 W. E	saitimore Stre	et, Baltimo	ore, MD 21223			
S Regis	tate trar	31. Date filed (Month, Day, Year) EEB 0 3 20		ar's Signature	bare	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martin 2012 049/05 4:02 PM January Medical 4a. Facility Name (#not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5225 Pooks Hill Road, Unit 1604South Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 231-38-5548 77 Director 1 XM 2 □ F January 1, 1935 Virginia Usual Residence of Dece or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director must be notified Maryland Montgomery Bethesda 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a 5225 Pooks Hill Road, Unit 1604 South 20814 United States or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. δ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 10 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗵 No Specify: Year or Dates. 1954-1962 Specify: "natural", 3 Widowed 4 X Divorced Completed d be filed within 72 hours Jental Hygiene. Irked other than "natura itic event, the Medical E. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use mixed) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Supervisory Electrical Engineer Department of the Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other transmant. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Price Milton Alene Judson Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Milton/Ex-Wife 15413 Langside Street, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 Burial 2 Cremation 3 Removal from State Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 22 Name and Address of Facility Robert A. P. Bethesda-Chevy Chase Bethesda, Maryland 20814 Pumphrey Funeral Home/ c. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee M01498 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ Sudden Cardiac disease or condition Medical resulting in death) Ventricular Ectopy **Examiner** Seque thally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami ension and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth ∠ ☐ read Social
☐ Pregnant at time of death
☐ Unknown for in the past 12 months? Month Year ed by the a Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 24 hours after death.

5 Funeral Director. After this certificate I letely filled in by the funeral director, pag 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D31001 Von 31, 2012 30. Name and address of person who completed dust of death (Item 23a) (Type, Print) 7500 Green wor Cnfr. Stuort Turkewitz, MD Green 6elt, MD 2077 C 31. Date filed (Month, Day, Year) 22. Registrar's Signa State FEB 0 Registrar DHMH 17 Rev 06-2011 ORIGINAL

12-00920

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 02845 **Dolores Netefor** 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 28, 2012 1929 hrs Madical Examiner Dolores Netefor Α. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year Funeral Months Days Hours Country) NY Director 080-07-0064 Sept 26, 1920 1 M 2 X F 91 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2X No show Montgomery Silver Spring or items 23a or 28a-f shormer must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matural", or items 23s or 28s-f sho 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14508 Homecrest Road 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No Specify: White 4 Divorced If Yes, Give Year or Dates: 1 Yes 2X No specify: <u>۾</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical **Baltimore**, MD 21215-0036 Agent Insurance Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Wilson Murray Be Dolores Laura Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Netefor Jones/daughter 118 Monroe St. #1404 Rockville, MD 20850 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 02/03/12 Woodbine, MD 4 Donation 5 Other Specify. 6 22. Name and Address of Facility 21. Signature of Funeral Service License ing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 23a, Part I, Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician **Physici** Retween Onset and failure. List only one cause on each line. /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and 평 AMENDED 23a, pt. II, 27, per me, g926 4-17-12 sm X UNPENDED attending physician or use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be evictin 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Med Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 [Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Urinary Tract Infection; Bullous Skin Rash; Pneumonia; Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of Chronic Obstructive Pulmonary Disease: Immunoglobulin autopsy performed? death? 1 ✓ Yes 2 No 1 Yes 2 No Deficiency 26 Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 / Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific February 1, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. State

DHMH 17 Rev 1/2001

Registrar

12-00907 **Dennis Newton** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of De	ath	Reg	ے ں د ی. No.		
Physician		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month	Dav Year	3. Time of Death 0126 hrs	
odical Examin		Dennis Newton		January 31	, 2012		
	4	Tall I deliky reality (if not included),	ity, Town, or Location	of Death	4c. County of Death N/A		
	٩,	Boll Occours (loopital		er 24Hrs 8 Date of Birth	Birth (MM/DD/YYYY) 9. Birthplace (State or		
Funeral Director	- 1		onths Days Hours	L Maria	5/1957 Foreign Country) MD		
k	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
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Aaryland 28a-f show	֚֡֝֝֝֝֝֝֡֝֝֝ ֚		. Zip Code	10	g. Citizen of What Cour		
th the Maryland 23a or 28a-f sho notified at once.	Ō١	2513 W. Lafayette Ave.	21216		USA		
s 23s	ᅙ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	cedent of Hispanic Ori	igin? (Specify Yes or No-	14. Race - Ameri	can Indian, Black,	
leath r	Fune	1 Never Married 2 Married Armed Forces? If Yes, sp	pecify Cuban, Mexican	n, Puerto Rican, etc.)	White, etc.	_	
after d	<u>.</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 No specify		Specify:Bla		
nours		during most of	sual Occupation (Give f working life. DO NOT		16b. Kind of Business/I	ndustry	
36 In 72 han "1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th 2 yrs. Manag	er		Tyrones (Chicken	
-003 I withi giene.	<u>ē</u> -	17. Father's Name (First, Middle, Last)	18.Mothe	r's Name (First, Middle, M	aiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. The record of the Medical covent, the Medical covents.	8	Rodney Newton, Sr.	Pea	rl Mae Den	nis		
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Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Itant: If item 27 is marked other than or other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	lace)				
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Baltimore, permit. Pages I an Department of He Important: Wile injury or other tr		21. Signature of Foneral Service Licensee	and Address of Facilit	March F/H altimore,	East 11(01 E.	
	-	23a. Part I. Epier the disease, or complications that caused the death. Do not enter the mo				Approximate Interval	
Physician Medical		failure. List only one cause on each line.				Between Onset and Death	
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	.	Sequentially list conditions, b					
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that the detail	∣ਣ	Part II. Other Significant Conditions	lying saass given in t		2 No 3 Pro	bably 4 🗹 Unknown	
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cords law requi	힏			autops perform	med? death?	completion of cause of	
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lital sician is cert lirecto	۵į	examiner? Hospital: 4 Inneticet 3 FD/Outpatient 3	- IOther 5	Nursing Home 5 1	Residence 6 Othe	r.	
of Viting Physical Inc.	밁	1 ✓ Yes 2 No II inpatient 2 ✓ ENOutpatient 3 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Wor	rk? 28d. Describe h	ow injury occurred		
on on cardin	흷	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2	No			
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	ctory, office building, e	etc. 28f. Location (S or Town, St		ural Route Number, City	
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Divis To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death o	occurred at the time, date	and place, and due to the	ne cause(s)	
T, William	ŝ	29b. Signature and title of certifier	29c. License numbe	er	29d. Date signed (Mo	onth, Day, Year)	
		ane IZ	O.C.M.E.		January 31, 201	2	
	ļ	30. Name and address of person who completed cause of death (Item 23a)	re Street Baltim	ore MD 21223			
		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimo 31. Date filed (Month, Day, Year) 32. Regletrar's Signature	——————————————————————————————————————	OIE, MD 21223			
Sta Regist		FEB 0 3 2012 Lener B. Jak					
DHMH 17 Rev 1/20	01	DOME ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ FEBRUARY 2012 3:40 AM NEUMAN NATALIE MAXINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 219-28-6041 1 🗆 M 2 🔀 F **Director** 05/02/1931 MD 80 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director be notified 1 Yes 2X No MD BALTIMORE BALTIMORE 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? .rs 23a o. -r must b Funeral 1500 BEDFORD AVENUE, #310 21208 USA items 2 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify WHITE 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ VARSUBSKY HARRY FEINSTEIN MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 BROADWAY ROAD, LUTHERVILLE, MD LYNNE KNESS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place MOSES MONTEFICRE WOODNOOR HEBREW 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/02/2012 BALTIMORE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metristatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last executed burial-trai Due to (or as a consequence of): physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Year Pregnant at time of death 5 Other (specify) signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 ☐ Unknown 1 Yes 2 No Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has bage 2 s autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Sill 2 **X**0No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined filled in 24 hours Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar (Check

29b. Signature

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and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

· Charles ST

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02848 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month weh 8:22 A M 20/2 NORA Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hopkines 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In yrs. last birthday) If Under 24 Hrs **Funeral Director** 1 □ M 2 🄀 F 04-19-1954 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD1 XYes 2 No BAUTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a REVERDY USA 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify: BLACK 3 ₩Widowed 4 □ Divorced Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL CROSSING GUARD (Specify only highest grade completed) BALTIMORE CITY and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ELNORA BINGHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau SON! 831 RE ROAD. BALTO, MD. 21212 VERDY 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2012 BATTIMORE, MD NATL 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN GREENE FUNERAL SOUS PA 21. Signatur 22. Name and Address of Facility TIMORE, MD. 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sutarachnord disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hnevism Sequentially list conditions If any, leading to Immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ctopic pregnancy
5 Other (specify) Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🔽 No Other: 1 Yes မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 🗋 Pending injury Accident Investigation Sulcide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) RES-000 2012

DHMH 17 Rev 06-2011

State Registrar Bultimore

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Horth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Physician/ Month Jong Moon Park 31 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia Lorien Nursing Home . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min South Korea 1 XM 2 - F 217-51-5450 86 Yrs 1925 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygene. do ther than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at event, the 10a. State 10c. City, Town or Location Director 1 ¥ Yes 2 □ No Baltimore N/A Maryland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? United States of America Funeral 21218 11 West 20th Street Apt. 70 America Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 Korean If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Ith and Mental Hygien 27 is marked other the r traumatic event, the Architect 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be file rtment of Health and Mental rtant: If item 27 is marked on njury or other traumatic eve ည Yul Soo Oh Chang Kyoo Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Oak Lane Towson, Maryland 21286 David In Soo Park/ son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot February 1 Burial 2 Cremation 3 Removal from State Evans Funeral Forest Hill, Maryland 3, 2012 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air 21. Signature of Funeral Service 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Ons, t and De t Immediate Cause (Final Condrovascular -mysiciam Atherosclero Hic disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ or in the past 12 months? Pregnant at time of death been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? 1 ☐ Yes 2 No certificate Yes 2 No 25. Was case referred to medical Division of Vital or Attending Physician: funeral director, 26. Place of Death (Check only one) æ examiner? Hospital 2 No Other: 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funera 1 Natural (Month, Day, Year) injury 5 Pending 1 🗆 Yes 2 🗆 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier workshi 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh SHIN MD WONSOCK

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JANUARY 22, 2012 7:00A M **JAMES EDWARD** PIERCE Medical 4b. City, Town, or Location of Death ROSEDALE 4a. Facility Name (if not institution, give street and number 4c. County of De **Examiner** BALTIMORE 811 1/4 ROSEDALE AVENUE Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Year) 212-42-7493 68 **Director** 1 🛛 M 2 🗆 F 8-13-1943 MARYLAND Usual Residence of Decedent 28a-f shov at Oa State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE ROSEDALE must be notified MD 1 Yes 2 XNo or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 811 1/4 ROSEDALE AVENUE 21237 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? 1 Pes 2 No Black, White, etc or ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: WHITE "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 721 (Give kind of work done during most of working l Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) GENERAL MOTORS 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental 7 is marked o မ EARL PIERCE, SR. ELEANOR CARRICK) traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,21237$ Department of Health an Important; If item 27 is any injury or others. NANCY M. PIERCE/WIFE 811 1/4 ROSEDALE AVENUE ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY 1-26-2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility CVACH ROSEDALE FUNERAL HOME agnature of Funeral Servi - Linensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, Examine que to for es a dorissiquence of cause. Enter Underlying Cause (Disease or injury DIABETIS that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical P.O. Box 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Year Pregnant at time of death Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?

1 Yes 2 XNo page or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita! Other: 2**X** No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how Injury occurred Certificate: (Month, Day, Year) XNatural 5 Pending death. 1 Yes 2 No M neral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) thin 24 hours a the Funeral D the Hospital Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) DD38048 JANUARY 31, 2012

State

30 Name and address

HOWARD

PHILADELPHIA ROAD SUITE 304 ROSEDALE,

21237

of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of I	Maryland		artment of				giene Reg. No.	012	028	51
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	/Medic Examin			f not institution, give	street and number	er)		4b. City, Tow	n, or Location	of Death		4c. Co	ounty of Deat	h	
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36	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "naturel", or iteme 23e or 28e-f ehow event, the Medical Examinat must be notified at	by Fun		ied 2 Married :	Armed Force 1 XYes 2 If Yes, Give Year or Date	□No WW1		If Yes, specify 0 1 ☐ Yes 2 🔀			tican, etc.)		Black, White	_{e,etc.} √hite	
Maryland 21215-0036	2 hou		(\$200)	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Oo	cupation	ost of workir	ng .	16b. Kind	of Business	/Industry	
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and	12 should be filled within h and Mental Hygiene. 7 ie marked other then "	Be		(First, Middle, Last) n William	-Dattit						May Po		4774770)		
Z	thould Me mark mark matic	မ		ame/Relationship (7		_	19b. Maili	ng Address (St					Town, State,	Zip Code)	
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3altimore,	ges 1 ar t of Hea if item or othe		20a. Method of Dis	position Cremation 3	Removal from St	1 ^	Place of Disponentery, cre	osition (Name o matory or other	place)		ate		ation - City or		
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Bal	permit. Pages 1 and 2 should be Depertment of Health and Menta important: if item 27 is marked eny injury or other treumatic evoluce.		Al	uneral Service Licen	Lion	3	1		phur S	pring	Road	Arbutı		yland 21	227
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976	ate be execu thysicien and the burial-tra	dical			d										
9		Med	IF FEMALE:											1	
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P.O.	requires thet the een signed by th hould be detache	Ph)		ificant conditions c	ontributing to dea	th but not res	sulting in the	underlying caus	e given in Pa	nı.	23e. Did	tobacco us	e contribute	to the cause of de	ath?
ds,	uires sign	d by									1]Yes 2□]No 3∏F	robably 4 🖽 🕏	ńknown
Ö	≥ <u>0</u> 0	Completed									24a. Wa			utopsy findings a	
Re	The law ite has b	dwo									per	opsy formed? 2 □ No	death?	completion of causes 2 No	use of
ta	en: T	0	25. Was case refe	erred to medical					26. Pl	ace of Deatl	Check only				
<u>></u>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ⊆	₹ N o	Hospital: 1 🗌 Inj	patient 2	ER/Outpatie	ent 3 DOA	Other: 4 🗆	Nursing Ho	me 5 Re	sidence 6	Other (Sp.	ecify)	
0	ng Ph Iter th Ineral		27. Manner of Dea	ith 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time Injury		Injury at Work?		28d. Describe	how injury	occurred		
Sio	tendii leath. tor: A the fu	catio	2 Accident	investigation				М	1 ☐ Yes 2		20f Looption	(Ctmot and	d Number or I	Rural Route Numb	hor
Division of Vital Records,	or At after d Direct in by	Certification:	4 Homicide	dataminad	28e. Place o building	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, s	treet, factory, or	fice			own, State)		TOTAL MODIO INDITIO	761,
_	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only	1 ☐ Cartifying Ph 2 ☐ Medical Exam	ninar: On the bas	sis of examina	owledge, dea ation and/or i	th occurred at to	he time, date my opinion, o	and place, death occur	and due to the	e cause(s) a	and manner a	as stated. ue to the cause(s))
	o the ithin 2 o the ample	Med	one) 29b. Signature an	d title of certifier	and manne	o stateu.		29c. L	icense numb	er		29d. Date	signed (Moi	nth, Day, Year)	
	F ≱ F 8		16	lyu-	B. 6)	A to	h	1437	22		, (:	30/12		
	ax 1		30. Name and add	dress of person who	completed cause	of death (Ite	m 23a) (Type	o, Print)	170	7				7122-6	
	1),		Deneen	Bowlin	mo	711Ma	uden	Choi	ce L	une.	Cator	nsri	11e, u	21228	1
		ate	31. Dat Tack M	32012	32. Re	gistra s Sign	a Pro	-							
-	Regist	rar	:::=	2919	- Charles	5									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ REHM FREDERICK TERMA-NI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Health & Rehab. Center Ellicott City Howard Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington DC **Funeral** 8. Date of Birth 1 KDM 2 - F Hours Min (Month, Day, Year) 09-05-1929 578-34-8708 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c, City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Howard Elkridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6391 Rowanberry Drive 21075 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Exes 2 No 1951

If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 21 No Specify 3 Nidowed 4 Divorced Specify: 1953 Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) General Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F မ Carl Prehn Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Cole - daughter \$245 Glenmar Road, Ellicott City, Maryland 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If i XXBurial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) Meadowridge Mem. Prk. 02-02-2012 Elkridge, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA Onset and Death Physician/ STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner B161 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No Yes 2 N 1 Yes **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my line wild go death occurred at the time date and place and due to the cause(s) and manner stated. (Check 23,2012. 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SuitE 34

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 02853 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Minnie Azelene Pauley 2012 01 10:45P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Presbyterian Home Towson 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min (Month, Day, Year) 1 🗆 M 2 🔀 F Director 235-28-4901 Usual Residence of Dece 91 09/19/1920 WV 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits the Maryland at Director notified 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 23a 21214 USA 6416 Glenoak Ave items death v Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Medical Examiner Armed Force Black White etc. ŏ þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after 2 **X**No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. 3 ▼ Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Leasing Company Customer Service the yr college event, Be Department of Health and Mentral Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Noel Isaac Whited 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9912 Maidbrook Rd., Parkville, MD 21234 Roy I. Pauley - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 【 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2-2-2012 Balto. Md. Gardens of Faith 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 100 6415 Belair Rd., Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ acute mi hour disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has to autopsy performed? Yes 2 No 1 ☐ Yes 2 ≥ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 M Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practitioner: To the basis of my however a date occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practitioner: To the basis of my however a date occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29c. License number 016 29d. Date signed (Month, Day, Year) MO

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Registrar

Greene

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenner M. Greene, vm 670/N. (4=165 ft, Sax 4104 Balthone, MD 21204

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2 Month Betty Campbell Robinson 2012 0450 a Medical February Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 5 **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 □ M 2 X F Hours **Director** 97 270-09-5344 1914 ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8214 Mary Lee Lane 20723 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 🕅 Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel Kohler Cecile Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Jenkins/daughter 8214 Mary Lee Lane Laurel, MD, 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/03/12 Woodbine, MD 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 15 CHEMIC COLITIS DAYS Medical Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown Day Year 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š DEMENTIA Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 🗌 Yes 2 🗌 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division safter death.

I Director: Aff of in by the further. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number **D** 6 4 3 9 5 FEBRUARY 2,2012

Registrar

DHMH 17 Rev 7/2009

State

CEDAR LANE

6336

COLUMBIA, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Albert Lloyd Reese 2012 February 8:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 419 Russell Avenue #320 Gaithersburg If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours $J_{
m an}^{
m (Month} 1^{D_{
m ay}, \; {
m Year})} 921$ Colorado 522-12-3903 91 **Director** 1**X** M 2 □ F Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2X No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a USA 419 Russell Avenue #320 20877 items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. ned Forces?
Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Fo ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 1945-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Federal Government Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Reese Margaret Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Reese/wife 419 Russell Ave. #320 Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 02/04/12 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Woodbine, MD 4 Donation 5 Other (Specify) . Signature of Funeral Se Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a Brain Tumor disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atten d be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 this certificate 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: $_4$ \square Nursing Home $_5$ XResidence $_6$ \square Other (Specify, Hospital 1 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After iniury 1 X Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I

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State Registrar

only one 29b. Signature and title of ce

30. Name and address of per

M.D.

who completed cause of death (Item 23a) (Type, Print)

29c. License number

D68677

501 N., Frederick Avenue Gaithersburg, MD 20877

29d. Date signed (Month, Day, Year)

Feb 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Joseph Michael Reagle, Sr PM 01 2012 1:50 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore Social Security Number 9. Birthplace (State or Foreign Country) New Jersey 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) July 3,1950 7. Age (In vrs. last birthday) 199-42-5841 61_{Yrs} 1 **X**M 2 □ F 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3327 Hiss Avenue 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

Pauline Eleanor Tracy

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

1/31/2012

Baltimore

E. University

MU

Fullerton, Maryland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3327 Hiss Avenue-Parkville, Maryland 21234

Feb. 4, 2012

HUSPITAL

Ph sician/ Medical Examiner

Department of F Important; If ite any injury or oth

For State Registrar

10a. State

MD

12

20a. Method of Disposition

29b. Signature and title of certifier

HARDIT

31. Date filed (Month, Day, Year)

Charaj

FEB 0

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMAL

Orville Albert Reagle

1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State

19a. Informant's Name/Relationship (Type, Print)

Dorothy Reagle-spouse

4 ☐ Donation 5 ☐ Other (Specify)

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shown notified at

ō

. Page 1 and 2 should be filed within 72 hours after death viment of Health and Mental Hygiene.
Itant, If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner multy or other traumatic event, the Medical Examiner multiples and the second of the seco

Baltimore, Maryland 21215-0036

ms 23a o must be

Director

Funeral

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Completed

Be

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with the Maryland

burial-trar physician attending

has

il or Attending Physician; after death.
Director: After this certifications

within 24 hours a

Division of Vital Records, P.O. Box 68760

Physician/Medical Examine Completed by page 2 Medical Certificate: To Be filled in by the

	21. Signature of Funeral Service Licensee		el and Cremation S Parkville,Maryland	ervices 21234
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not enter the mode of dying, such as cardiac cause on each line. SEVERE NECROTIZING PA		Approximate Interval Between Onset and Death
	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of): SEVERE SEPSIS Due to (or as a consequence of).		28 DAYS
	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1	23d. Date of de Month	livery Day Year
•	Part II. Other significant conditions cont	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
			autopsy prior to performed? peath?	topsy findings available completion of cause of
	25. Was case referred to medical examiner? 1 Yes No Ho	26. Place of Death (Checospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ck only one) Iome 5 Residence 6 Other (Spec	. (4. A
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ru City or Town, State)	ral Route Number,
	(Check 2 L Medical Examine	ian: To the best of my knowledge, death occurred at the time, date and place, a r: On the basis of examination and/or investigation, in my opinion, death occurred a Practitioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place, and due to the	cause(s) and manner stated

MEMORIAL

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Joseph Catholic
urch Cemetery

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State

Registrar

UNION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hilda Gertrude Rhodes 2012 4:30A Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 💢 F Director 082-20-1335 84 May 15, 1927 Brooklyn, New York Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2 XNo Maryland Baltimore Parkville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be r 23a Funeral 10 Kelbark Court 21234 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. by 1 Never Married 2 X Married JAN 31 2013 Baltimore, Maryland 21215-0036 Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other the traumatic event, the Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Kapchan other traumatic Fannie Schincz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traconce. Thomas Rhodes (Spouse) 10 Kelbark Court, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 01, 1 Durial 2 Dremation 3 Removal from State Evans Funeral Chapel-Bel Forest Hill, Maryland 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 0 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or new failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PANCREA. disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be HODES HILDA Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 1/2 r Year Month Day Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performe 2 No 1 Yes or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury Natural injury 5 Pending Accident Investigation hin 24 hours after death the Funeral Director, Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one within To the

Registrar

DHMH 17 Rev 06-2011

State

29b. Signature and th

30. Name and ad

Print)

son who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date Physician/ GERTRUDE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Season's Hospice Randallstown Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 11/08/1945 Maryland 214-44-5180 1 🗆 M 2 🕱 F **Director** 66 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Director notified Maryland Frederick Emmitsburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral United States 21727 220 East Main Street items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force ō Examin 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 → Widowed 4 □ Divorced If Yes, Give "natural", White Year or Dates it of Health and Mental Hygiene.

If item 27 is marked other than "natu or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales 11thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gertrude Wheeler Meta Stanovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3809 Dunsmuir Circle, Chase, Maryland 21220 Veronica Raynor /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 3,2012 Glen Burnie, Maryland Atlantic Crematory f Ineral Service Name of Address (FERM), HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events for use as the burial-tra resulting in death) Last Due to (or as a consequence of): signed by the attending physician is be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 ∐ Yes ∠ L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 22 No After this certificate has director, page 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Registrar

only one 29b. Signature and titl

29c. License number

Date signed (Month, Day, Year)

12-00818 Zachary Rose

Мe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	0.	u.o o.	iviai yiai i		tificate o	f Death			, g.oe R	eg. No.		
Physicia	n/	1. Decedent's Nam		e,Last)							2. Date of Dea Month		Year	3. Time of Death
dical Examir	ner	Zach	-			se					January 2	8, 201	2	0350 hrs
		4a. Facility Name (i			et and numb	er)		Davids	wn, or Locatio onville	n or Death			County of Death nne Arundel	1
Funeral		5. Social Security N		6. Sex	7.	Age (In yrs. I	ast birthday)	If Under	1 Year If Ur	nder 24Hrs.	8. Date of Bi	rth (MM/D		thplace (State or
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	ł	Usual Residence of									09 23	1775		
w any		10a. State	10b. County			10c. City,	Town or Locat							10d. Inside City Limits
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eath w	Funeral	1 X Never Marri	ed 2 M		Armed Force				Cuban, Mexic				White, etc.	roan maan, black,
ifter d	by F	3 Widowed	4 Div	orced If Ye	Yes es, Give Year Dates:	Z X NO	1 🔲	Yes 2X	No speci	fy:		5	Specify:	White
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Ja with giene	Completed	12 17. Father's Name	(First, Middle	Last)			Labo	rer	18.Moth	ner's Name	(First, Middle,	Maiden S		ruction
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medica	Be	James Ga									i Renee			
21 could b d Mer	٥	19a. Informant's Na	ame/Relations	hip (Type,	Print)		19b. Mailin	g Address	(Street and N	umber or R	Rural Route Nu	nber, Cit	y or Town, State	e, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours a celth and Mental Hygiene. tem 27 is marked other than "natural traumatic event, the Medical Examin		Terri R.		nski	- motl						, Jessu		ID 20794 ocation - City or	
		20a. Method of Dis 1 X Burial 2		3 🗌 F	Removal from		Place of Dispos crematory or ot		or cemetery,					
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Baltimorr permit. Pages 1 Department of 1 Important: If injury or other		21. Signature of Fy	L Service	12 I	000	()								eral Home at e, MD 21075
Physician	\dashv	23a. Parl I. Enter th	ne disease, or	complicati	ions that caus	ed the death	. Do not enter t	the mode of	dying, such as	s cardiac o	r respiratory an	est, shoo	ck, or heart	Approximate Interval
/Medical		failure. List on Immediate Cause (_{ne.} Itiple Injuri	es								Between Onset and Death
Zammer		or condition resulti			to (or as a co	nse que nce o	f):							
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Box 687 e death certific the attending p	hysician/	1 Yes 2 1	No 9 🔲 Un	known 9			5 O	ther (Specifi	v)			į		
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of Vital Records, P.O. as Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detact	ā Ā										1 Ye	s 2 🗸	No 3 Pro	bably 4 Unknown
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Reco	Completed										perfo 1 ✓ Yes	rmed?	death?	es 2 No
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n of ding Ph	<u></u>	27. Manner of Deal	th 5 Pen	dina	28a. Date of (Month, Da Jan 28, 20	injury ly Year) 12	28b. Time of : 0331 hrs	injury 28	c. Injury at Wo		28d. Describe Passenger		icle i nvolv ed	in collision
Division its or Attending as after death.	ication	2 Accident	Inve	stigation	28e. Place o	f Injury - At h	ome, farm, stre	et, factory, c			28f. Location (Street ar	nd Number or Ri	ural Route Number, City
Divi	Certific	3 Suicide 4 Homicide		d not be rmined			d / Highway		0.		or Town,	State)	8, Davidsonvi	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the	cal C	29a. Certifier 1			To the best o	f my knowled	ge, death occu	rred at the ti					d manner as sta	
To the Howithin 24 h To the Fur	ed.	one) 2		and	the basis of e manner state		nd/or investiga				at the time, date		ce, and due to the	
	ž	29b. Signature end	title of certific	er /	//	0			License numb	er			ate signed (Mo	
6 nm			YN	1,	1t				O.C.M.E.			Janu	uary 28, 201	۷
5 m		30. Name and addr Jack Titus	/				n 23a) r 900 W.	Baltimore	Street R	altimore	MD 21223			o I
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State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 Physician/ Month Rhoderick Homer Sechrist 3:44PM DANUA 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days May 9, 1936 Hours Months 577-54-2606 Michigan Director 75 1 X M 2 □ F 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 😾 No MD Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 11440 Old Prospect Hill Road 20769 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ō Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Specify: White Year or Dates. 1957-59 permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicall 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechanic Auto Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Paul Sechrist Anne Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Benjamin Sechrist/son 179 Meadow Hill Rd. Manchester, ME 04351 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 02/02/12 | Woodbine, MD 21. Signature of Funeral Service Licer Going Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the attending physician and ched for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. RNSION 1 Yes 2 No 3 Probably 4 Nnknown DIAKE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or resignation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse occurred at the time, date and place, and due to the cause(s) and manner as stated ROAD LANGHAM MD 00d L KNOX 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 112P Month NOV Physician/ 201 Zear Jona Simpson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** arro ronsinans DYKESMIR /If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 1 Year Social Security Number 7. Age (In vrs. last birthday) Funeral 1 - M 2x x Days (Month, Day, Y 1-25-19 Months Hours Min. MD Yrs Director 216-34-7484 78 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at death with the Maryland Director Examiner must be notified 1 🗌 Yes 2 🌁 No MD Howard Laure1 10g. Citizen of What Country? 10f. Zip Code ò 10e. Street and Numbe items 23a Funeral 10678 Old Bond Mill Road 20723 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transmitted. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ٩ Walter Knisley Carmon Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra A. Miller - daughter 1834 Montreal Rd., Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02-03-2012 Meadowridge Mem. Park Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatu MMP, Inc, 7250 Wash Blvd., Elkridge, MD 21075 ノ
よ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of) burialattending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |ል 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should peen 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5 gm

30 Name and address of pe

DHMH 17 Rev 7/2009

State Registrar 30

on who completed cause of death (Item 23a) (Type, Print)

295

212012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John J. Seisman, III 2012 January 11:48 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5304 Balistan Road Rosedal If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Months Days (Month, Day, Year) 215-64-8332 **Director** 1 👿 M 2 🗆 F 57 June 27,1954 Maryland items 23a or 28a-f show her must be notified at 10a. State 10h County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale MD 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 United States 5304 Balistan Road within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 X Married 2 XNO ☐ Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify "natural", Completed 3 Widowed 4 Divorced Specify White the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Truck Driver Construction other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည be John J. Seisman, Jr. Doris M. Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 5304 Balistan Road Mrs. Dinah A. Seisman (Wife) Rosedale, Maryland 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ${\bf X}$ Burial 2 \square Cremation 3 \square Removal from State injury or Department of Important: If Sacred Ht. of Jesus Cem. 2/4/2012 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signatule Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. avenue Dundalk, Md 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director; After this certificate has been signed by the attending physician and
etely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic prog. 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 NO 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mauner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the vest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signate H-0063476

State

10 V

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BLUD BALTIMERE 32 Registrar's Signature

Registrar FER () 3 201

Date filed (Month, Day,

CAMP

address of person who completed cause of death (Item 23a) (Type, Print)

MD 2123/0

DR. DAVID MADDER

12-00882 Walter Schultheis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			(Certifica	ate of	Death			Reg	3. No. 2	0 1	2 0286
Physicia		Decedent's Name	e (First, Middle,L	·				1.1.			Date of Death Month		ır	3. Time of Death 0647 hrs
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				Medical Cen			"	Baltimore	or Eocation (or Dea th		1	N/A	
Funeral		5. Social Security N	lumber 6.	Sex	7. Age (In y	rs. last birt	nday)	If Under 1 Ye	ear If Unde		Date of Birth		9. Birt	hplace (State or
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5-0036 iled within 7 Hygiene. to ther than	Completed	12 Year		est)			Carı	nan	18.Mother	's Name (Fir	st. Middle. M	aiden Surname		au
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	8			ultheis	Ir.				1100000	elyn S				
21, ould b d Men s mar	리	19a. Informant's Na	me/Relationship	(Type, Print)		19b	. Mailing .	Address (Str				er, City or Tow	n, State,	Zip Code)
MD d 2 sho lth and lth and unati		Mrs. Dor		chulthei		- 1						k, Mary		
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Page ment of or oth		4 Dongtion 5	Other Spec	eify:		Hillt		ervice			2012	Towson	, Ma	ryland
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8760, ificate be ig physic s the bur	≥ ∣	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes,		pregnancy 2	☐ Feta	Ideath 3	Ectopic	pregnancy		23d. Date of Month		ay Year
Box 68 death certif	ician/	past 12 months	_	4 Pregr	ant at time o		=	(Specify)						
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Division of Vital Records, tat or Attending Physician: The law require is after death. al Director: After this certificate has been side in by the funeral director, page 2 should be	위	1 ✓ Yes : 27. Manner of Deat	2 No	28a. Date (Month			ime of Inj		jury at Work			ow injury occurre		
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vision Atto	<u>ड</u>	2 Accident 3 Suicide	Investig	28e Plan	e of Injury -	At home, fa	rm, street	factory, office	building, et	c. 28f.			r or Rur	al Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide	determi								or Town, Sta	ate)		
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To the Ho within 24 P	Medicai			ner:On the basis and manner s	tated.	on and/or in	vestigatio		on, death oc	curred at the				
	2	29b. Signature and	the of certifier						.M.E.		}	29d. Date signe January 31		
	-	20. Name and add	MLA C	o completed	es of do-th	(Itom 22=1						oundary 51	. 2012	
5×11		30. Name and addre Ana Rubio N		tant Medical I			/. Baltin	nore Street	, Baltimo	re, MD 21	1223			
Sta	te	31. Date filed (Mont	h, Day Year)	3 2. Re	egistrat's Sig	na ure	1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Mary	Vitoline	Szimanski
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lary vitoline 32		o tarto or monytania : Dopara	icate of Death	Reg. No. 2012 028	36
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	Szimanski	2. Date of Death Month Day January 30, 2012 3. Time of Death 1527 hrs	
ngaloai Exami		Mary Vitoline 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		_
		2606 W. Greenspring Avenue	Joppa	Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1. 1	Yrs. If Under 1 Year If Under 24Hrs Months Days Hours Min	1=	
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daryland 28a-f show 1 at once.	Director	MD Harford 10e. Street and Number	Joppa 10f. Zip Code	10g. Citizen of What Country?	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		2606 Greenspring Avenue	21085	United States	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates:	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:		
hours a			 Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use reti 		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than r event, the Medica	Be Co	17. Father's Name (First, Middle, Last) John August Modigh		e (First, Middle, Maiden Surname) Deth Mildred Orwig	
MD 21 d 2 should lith and Me n 27 is ma	٤	19a Informant's Name/Relationship (Type, Print) Mr. Eward H. Szimanski (Husband)	19b. Mailing Address (Street and Number or I 2606 Greenspring Ave	Rural Route Number, City or Town, State, Zip Code) e. Joppa, Maryland 21085	
10re, land at of Heal it of Heal it. If item		1 X Burial 2 Cremation 3 Removal from State	e of Disposition (Name of cemetery, natory or other place) ed Ht. of Mary Cem 2/	Date 20c. Location - City or Town, State 74/2012 Dundalk, Maryland	
Baltimore, permit. Pages I ar Department of Hee Important: If the		4 Donation 5 Other Specify: 21. Signature of Funeral Service-Licensee	22. Name and Address of Facility Duda-Ruck runeral	Home of Dundalk, Inc.	
Physician	H	23a. Part I. Enter the disease, or complications that caused the death. Do	17922 Wise Ave. Dur not enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart Approximate Inter-	
Medical Examiner			ies complicating cardi	ovascular disease Between Onset an	and
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ecuted and transit	al Exa	d			
60, ate be executed hysician and burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnant	a-f,per me,g924 2-8-12	2 Sm 23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal death 3 Ectopic pregna		
P.O. Erres that the disagned by the	by Ph	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknow	
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Sion Attendary r death.	catio	28e Place of Injury - At home	1 Yes 2 X No , farm, street, factory, office building, etc.	subject fell on stairs 28f. Location (Street and Number or Rural Route Number, C	City
Division spital or Attence tours after death neral Director: filled in by the	Certification:	4 Homicide determined (Specify) found:	Residence	or Town, State) 2606 W. Greenspring Ave. Joppa, MD.	ıg
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, of the control one) 2 Medical Examiner: On the basis of examination and/of and manner stated.			
	¥	29b. Signature and title of certifier	29c License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 31, 2012	
		30. Name and address of person who completed cause of death (Item 23	a)		
<i>N</i> S	ate	31. Date filed (Month, Pay Year) 32. Kegistrar's Signature	W. Baltimore Street, Baltimore, MI	U 21223	_
Regis	trar	31. Date filed (Morth, Pay Year) 2012 32. kegistrar's Signature	pare		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 Charles Spence, Sr. 30 2012 5:02P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) **Director** 223-38-7137 1 X M 2 🗆 F 78 04/17/1933 Virginia Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified at 1 Tes 2 X No MD Anne Arundel Glen Burnie 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a 21060 U.S.A. 1016 Edgerly Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner rmed Forces?
X Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Machine Shop Foreman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cox Jacob Fred Spence Wetah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 394 Scarlet Oak Drive Millersville, MD 21108 Mrs. Brenda Wilkinson/Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 🗆 Burial 2 🗀 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highland Memory Gdns 02/02/2012 Dublin, Virginia e of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD MO1479 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sepsis Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner piration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires Division of Vital Records, To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 are:
Ts after dearn.
Trail Director: After this cerus.
To by the funeral director, pe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation Could not be completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eitl 2001

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:10 P January 31, 2012 Zelda Schiffman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Avenue, Chevy Chase Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 🗆 M 2 🔀 F Months Hours Ma^{(Mont}28^{ay, Y}13912 New York 99 085-07-6001 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Montgomery Chevy Chase 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20815 United States 8100 Connecticut Avenue, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 🛛 No Specify:White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry
National Institutes 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Health Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boris Schiffman Miriam Eisner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois C. Greisman/Friend 3809 Griffith Place, Alexandria, Virginia 22304 20b. Place of Disposition (Name of Monte of Monte of Cremator Um, Inc. 20c. Location - City or Town, State 20a. Method of Disposition February 2. 1
Burial 2
Cremation 3
Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Robert A. 1 Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 Fumphrey Funeral Home/ 7557 Wisconsin Avenue Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Dysphagia Due to (or as a consequence of):

Physician/ Medical Examiner

permit. Page 1 a Department of H Important: If ite any injury or ot

Physician/

Medical

10a. State

Examiner

Funeral

Director

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Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

Fant: If item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examiner must be I

within 72 hours after death

Baltimore, Maryland 21215-0036

notified at

Director

Funeral

by

Completed

Be

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signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur

Division of Vital Records, P.O. Box 68760

edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury that initiated events resulting in death) Last	b. Anemia Due to (or as a consequence of): c. Late Effect Cerebral Vascular Diseated Due to (or as a consequence of): d	ise
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Completed by Physician/Medical	Part II. Other significant conditions co Renal Insufficie Advanced Age	ontributing to death but not resulting in the underlying cause given in Part I. \mathbf{ncy}	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
ပ္တို	25. Was case referred to medical	26. Place of Death (Check o	1 100 2 23 110
To Be	overniner?	Hospital:	e 5 🔀 Residence 6 □ Other (Specify)
	27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🔲 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of sinjury 28c. Injury at work? M 1 \(\subseteq \text{ Year} \) No	d. Describe how injury occurred
edical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	off. Location (Street and Number or Rural Route Number, City or Town, State)
edica	(Check 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at the property of the time, date and place.	e time, date and place, and due to the cause(s) and manner stated.

29c. License number

#305, Bethesda, Maryland 20814

D35579

29d. Date signed (Month, Day, Year)

2012

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

10

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Miller, MD 8218 Wisconsin Avenue,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:26 PM Jan Ben Savoy 2012 an Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Union Memorial Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours 216-74-4400 Director 55 11/28/1956 Maryland 28a-f show 10d. Inside City Limits 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🖵 Yes 2 🗌 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1607 Gorsuch Ave. 21218 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S. Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 🗌 Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Master Craft (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. 12th Grade College (1-4 or 5+) Warehouse Studios other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be flik tment of Health and Mental I tant: If item 27 is marked o မ Joseph Savoy Sr. Thelma Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Savoy(Brother) 2047 Division St., Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State on-site Crematory 02/03/12 Baltimore, MD 4 Donation 5 Other (Specify) ²² Name and Address of Facility Joseph H. Brown Jr., Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ 110075 disease or condition resulting in death) noxic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Abase Cause (Disease or injury Alcohol use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ıding physician Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) ed by the a detached f Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ₺ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ 1 Ves 2 No page 2 has 1 ☐ Yes 2 ☐ No I or Attending Physician: after death.
Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 10 1 Tyes 2 1 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c, Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State

, 201 E. University PKNY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union

FEB 0 3 2012

Memorial

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	man, III 1- For State Registrar	State of Mary		ment of ficate of		d Menta		Reg. No. 20	12 0286	
Physician/ Madical Examiner	Decedent's Name (First, I Edward Andr		TTT				2. Date of De Month January		3. Time of Death 1700 hrs	
	4a. Facility Name (if not inst	titution, give street and		4	b. City, Town, or			4c. County of D	Death	
Funeral	10066 Padva Way 5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	Owings Mill		24Hrs. 8. Date of B	Baltimore	County Birthplace (State or	
Director	214-08-6636	1 XM 2 F		Yrs.	Months Days		Min	- IF		
any	Usual Residence of Deceder 10a. State 10b. Co		10c City To	own or Location	on				10d. Inside City Limits	
		ltimore		gs Mil					1 Yes 2 No	
the Maryland a or 28s-f sb tiffed at once Director	100.66 Do door	F.7			10f. Zip Code			10g. Citizen of What		
r death with the Maryland or items 23a or 28s-f show must be notified at once. Funeral Director	10066 Padua		ecedent Ever in U.S.	13, Was	21117 Decedent of His	panic Origin	n? (Specify Yes or N	United St	rnerican Indian, Black,	
r death with or items 23 must be m	1 Never Married 2	1 Yes		If Ye	s, specify Cuban	, Mexican, P	Puerto Rican, etc.)	White, e		
urs after	3 Widowed 4 15. Decedent's Education	Divorced If Yes, Give Y or Dates: (Specify only highest gi			Yes 2 X No	s <i>pecify:</i> ion (Give kir	nd of work done	Specify: 16b. Kind of Busin	White ess/Industry	
6 n 72 hour an "natu cal Exan	Elementary/Secondary (0)-12) College	(1-4 or 5+)		st of working life.					
215-0036 be filed within 7 tral Hygiene. riced other than ent, the Medica	12 17. Father's Name (First, Mi	iddle, Last)		Mecn	anical I	_	Name (First, Middle,	Trident Maiden Surname)	3	
1215 I be file ental Hi narked o went, th	Edward Andre	ew Tillman,	Jr.				nia C. Job			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Rela Edward Andre	ew Tillman,	(Father)				4	mber, City or Town, S Maryland 2	· •	
ITE, N. S. I and of Health	20a. Method of Disposition 1 Burial 2 Crem	nation 3 Removal	crei	matory or oth	tion (Name of cer er place)		Date February 04	20c. Location - Ci	· '	
Baltimore, permit. Pages I as Department of Hes Important: If ite	4 Donation 5 Oth 21 Signature of Funeral Se	er Specify:	St.		oiscopal C Cametery	· ILLL CA.	2012	Monkton,	_	
Bal permi Depar Impo	SULLULU STREET	Call		E	vans Fune 6924 York	ral Cha Road M	pel & Cremat ankton, Mar	ion Service yland 21111	s-Manktan	
Physician /Medical	23a. Pert I. Errie the dise s failure. ↓ st ∈nly one	ause on each line.		o not enter th	e mode of dying,	such as care	diac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and	
€xaminer	Immediate Cause (Final dis or condition resulting in dea		ce Head Trauma a consequence of):	a					Death	
70	Sequentially list conditions, if any, leading to immediate	b	a consequence of):							
ted Insit Examiner	cause. Enter Underlying Co	ause c.	a consequence of):							
executed an and al - transit ical Exe	events resulting in death) L	d	a consequence or j.							
~ a igi a ⊘	UNPENDED	AMENDE						1		
Box 68760 s death certificate but attending physical polysical properties of for use as the but hysician/Men	IF FEMALE: 23b. Was decedent pregnan past 12 months?	t in the	s, outcome of pregnar	2 Fet	al death 3 [Ectopic p	pregnancy	23d. Date of de Month	Day Year	
Box e death c the attented for us	1 Yes 2 No 9	Unknown	gnant at time of death nown	¹ 5 Oth	er (Specify)					
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Medical Certification: To Be Completed by Physician/Medical Certification:	Part II. Other significant co	onditions contributing	to death but not resu	alting in the ur	nderlying cause g	iven in Part			e to the cause of death? Probably 4 Unknown	
ords, F w requires us been sign should be	N	· · · · -						an 24b. We	re autopsy findings available	
Records, The law requires ficate has been sig page 2 should be Completed								orm <u>ed</u> ? dea	r to completion of cause of th? Yes 2 No	
Division of Vital Records, tal or Attending Physician: The law requint as after death. Al Director. After this certificate has been si led in by the funeral director, page 2 should striffication: To Be Completed	25. Was case referred to me examiner?	edical Hospital:					heck only one)			
of Ving Physical After this Tolem.	1 ✓ Yes 2 No 27. Manner of Death	28a Da	te of Injury 28	NOutpatient Bb. Time of In		y at Work?	28d. Describe	Residence 6 🗸		
ision of ' Attending Ph or death. ector: After i by the funeral				OUND: 655 hrs	1 🗆 ነ	res 2 🗸 N	Car fell off	jack onto subjec	;t 	
Division spital or Attentours after death nous after death neral Director: filled in by the Certificati	3 Suicide 6	Could not be	ace of Injury - At homo	e, farm, stree	t, factory, office b	uilding, etc.	or Town.		or Rural Route Number, City	
Divis To the Hospital or A within 24 hours after completely filled in b	4 Homicide 29a. Certifier 1 Certifyl	ng Physician: To the b	est of my knowledge,	death occum	ed at the time, da	ate end place	e, and due to the cau	ise(s) and manner as	stated.	
To the Howithin 24 h To the Fun Completely	29b. Signature and title of c	Examiner: On the basi and manner ertifier	s of examination and/ r stated.	or investigati	on, in my opinion		erred at the time, date		(Month, Day, Year)	
	:111	7		24	O.C.I			February 1, 2		
	30. Name and address of po			•	A/ Baltimar-	Stroat D	altimera MD 0	1222		
State	Russell Alexander 31. Date filed (Month, Day,)		Medical Examin	900 \	v. pallimore	Sueet, B	altimore, MD 21	1223		
Registrar	31. Date filed (Month, Day,)	3 2012	hour B	. pa	Kel					
DHMH 17 Rev 1/2001				ORIGINAL	-			0	CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Emmanuel Myro		<u>Ive Alori al</u>	tate of Maryla d #20b Per	and/Department	rtment of rtificate of	Health and Death	d Mental		2 (Reg. No.	012 0287
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Mid EMMANUE)		RON	ТНОМ	AS		2. Date of Dea Month January 2	Day Year 27, 2012	1722 nrs
}		4a. Facility Name (if not institut 3212 Saint Lukes La	_	imber)		4b. City, Town, or Gwynn Oak			4c. County of Baltimore	County
Funeral Director		5. Social Security Number 417-80-8017	6. Sex	7. Age (In yrs. I 52	ast birthday) Yrs	If Under 1 Year Months Days			irth(MM/DD/YYYY) 22 1959	Birthplace (State or Foreign ALABAMA Country)
nd thow any	_	Usual Residence of Decedent 10a. State 10b. County MD BALT	, IMORE		Town or Locati					10d. Inside City Limits 1 X Yes 2 No
vith the Maryland 23a or 28a-f show	I Director	10e. Street and Number 3212 SAINT LI		_ Gn		10f. Zip Code 21207			10g. Citizen of Wha	at Country?
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		Married Armed Formation 1 Yes, Give Year or Dates:	2 A N	Y 1		, Mexican, Puer specify:	rto Rican, etc.)	White, Specify:	BLACK
0036 within 72 hour iene. ner than "natu Medical Exan	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12) College (1 2 YR	-4 or 5+)			DO NOT use r	etired)	16b. Kind of Busi	iness/Industry
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than tic event, the Medica	To Be Co	17. Father's Name (First, Middle RAYMOND THOM) 19a. Informant's Name/Relation	AS ship (Type, Print)		19b. Mailing		SARA	н Е. н	Maiden Surname) IICKS mber, City or Town,	State, Zip Code)
lore, MD ges 1 and 2 sho it of Health and it if item 27 is other traumati		JENNIFER WEST, 20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal fro	om State	Place of Disposi crematory or other	tion (Name of cerr er place)	netery, 2	/13/2012		City or Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service			22. N	NS CEMETI ame and Address 474 LAND(of Facility J			HAM, MARYLAND EKAL HOME, INC. ARYLAND 20785
Physician • Medical • Examiner	1	23a. Pah I. Enter the disease, of failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line. _{e a.} Hypertensiv	e Cardiovas	cular Disea		such as cardiad	or respiratory arr	rest, shock, or hear	t Approximate Interval Between Onset and Death
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b Due to (or as a	consequence of						
cuted nnd transit	dical Examiner	(Disease or injury that initiated events resulting in death) Last	С	consequence of	·):					
60, ate be executed hysician and te burial - transit	- 00 ⊩	UNPENDED IF FEMALE:	AMENDED 23c. If yes, o	outcome of pregr	nancy			<u>.</u> .	23d. Date of de	elivery
Vital Records, P.O. Box 68766 bystein: The law requires that the death certificate this certificate has been signed by the attending phys I director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in to past 12 months? 1 Yes 2 No 9 Ur	the 1 Live b	irth ant at time of dea	2 Fet	al death 3 er (Specify)	Ectopic preg	nancy	Month	Day Year
is, P.O. quires that the en signed by uld be detach	ā	Part ii. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I.		s 2 No 3	ute to the cause of death? Probably 4 Unknown ere autopsy findings available
Recorc The law re ifficate has be r, page 2 sho	Completed	25. Was case referred to medical	at a			26 Place of	of Death (Chec	autop perfor 1 Yes	prior prior prior des	are autopsy liftings available or to completion of cause of ath? Yes 2 No
4	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 I		ER/Outpatient 28b. Time of In	3 DOA C	Other Nurs	sing Home 5	Residence 6 🖊	
Divisio pital or Atter ours after deat leral Director filled in by the	Certification:	2 Accident Inve 3 Suicide 6 Cou 4 Homicide	estigation	of Injury - At ho	me, farm, stree	, factory, office bu		28f. Location (S or Town, S		or Rural Route Number, City
To the Hos within 24 h To the Fun completely	edical	one) 2 Medical Exa	thysician: To the best aminer:On the basis of and manner st	f examination an		on, in my opinion,	death occurred		. ,	
		29b. Signature and title of certifi	1. 16			29c. License O.C.M		_	January 28,	(Month, Day, Year) 2012
51			puty Chief Medic	al Examiner	900 W. B	altimore Stree	et, Baltimor	e, MD 21223		
Sta Regist	ate	3 Transfiled (M3nf2012Year)	22. Re	trar's Shrietur	60					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year 29 12:05 P M Tweedale January Suzanne Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 5555 Gayland Road Arbutus If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month. Dav. Year) Months Days Hours Min. **Director** 216-66-4525 1 □ M 2 🛛 F 57 Yrs Dec.30. 1954 Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland notified at Director 28a-f 1 🗌 Yes 2 😾 No MD Baltimore Arbutus 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n ò Funeral 5555 Gayland Road USA 21227 items ? death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or iten edical Examiner r 11. Marital Status Armed Forces? þ 1 Never Married 2X Married of and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", or rother traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie A. Grocki Norman Joseph Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 137 New Windsor Maryland 21776 David Price-Son Department of Healt Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date TXX Burial 2 Cremation 3 Removal from State Loudon Park Cemetery Feb.2,2012 Baltimore Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. Signature of Ineral Service Licenses (V. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ a Sudden cardiac death minute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 30 years Coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran the burial-trai Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death 4 ☐ Pregname been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hyperlipidemia page 2 s autopsy performed? 1 Yes 2 X No Tobacco abuse funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 😿 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After t 1 X Natural 5 Pending injury Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 horander to the sound the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year, 29c. License number Attending 2 D25861 January 30,2012 Physitan 3 30. Name and address of person who comple ted cause of death (Item 23a) (Type, Print) Bruce R. McCurdy, M 716 Maiden Choice Lane Suite 101 Baltimore Maryland 21228 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERI 5.30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harwood Anne Arundel Mandrin Hospice House 7. Age (In yrs. last birthday) Social Security Number 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 225-50-4788 Director 1 M 2 D F Yrs 72 June 21 1939 VA Usual Residence of Deceden 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Pasadena Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 USA 7740 B Outing Avenue death v 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) in and Mental Hygiene.
If is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Local Union #101 Carpenter 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is morany injury or other. ည Driskill Templeton Verty Albert F. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7740 B Outing Avenue, Pasadena, MD 21122 Betty C. Templeton (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 03 1 Burial 2 XCremation 3 Removal from State Feb. Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 2012 of Funer Sign 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Part 1. Enter the disease, or cor shock, or heart failure. List only Approximate val Betweer Immediate Cause (Final Ph.si.i.n disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury) Examine Due to for as a consectioned cry burial-transif Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death Unknown signed by the at Id be detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown should Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 🗌 No Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Tes 2 No Other: ၉ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence & Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred HOUSE 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie a 02 ppleted cause of death (tem 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthda 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Days Months 99 Country **Director** MD sidence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** must be notified 1 Yes 2 X No ō 270 10g. Citizen of What Country? 23a items Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☑ Widowed 4 ☐ Divorced "natural", Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the **SECRETARY** BOARD OF EDUCATION of Health and Mental Hygie item 27 is marked other i other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL **GOLDBERG** REBECCA LICHTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLAN FORMAN/SON 7203 ROCKLAND HILLS DR, #404, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 02/02/2012 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner and -transit that initiated events resulting in death) Last signed by the attending physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🕅 No ASSISKED ည ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specif 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🙀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R131846 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aux, 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

egory T. Wilki		1- For State Registrar	ryland / Depa <i>Cer</i>	rtment of tificate of		Mental Hy	Reg	J. NO.	2 0287
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Gregory T. Wi	lkins				2. Date of Death Month February 1,	Dav Year	3. Time of Death 1412 hrs
		4a. Facility Name (if not institution, give street a 205 Water Fountain Way #302	nd number)	41	o. City, Town, or Lo Glen Burnie	ocation of Death		4c. County of Deatt	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs.	. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		215-58-1546 _{13M 2}	F	53 Yrs.	Months Days	Hours Min.	12/13		ountry) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
k	ō	Maryland Anne Arunde	el			sadena			1 Yes 2 No
e Mary or 28s-	Director	10e. Street and Number 8417 Maryland Road			10f. Zip Code	21122	100	g. Citizen of What Cou US	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 12. Wa	s Decedent Ever in U.		Decedent of Hispa s, specify Cuban, M	anic Origin? (Sp			ican Indian, Black,
fter dea			Yes 2 X No ve Yeer	1 .	Yes 2 No	specify:		Specify: W.	hite
hours a	ted by	15. Decedent's Education (Specify only higher			s Usual Occupation st of working life. D			16b. Kind of Business/	Industry
D36 thin 72 ne.	Completed	Elementary/Secondary (0-12) Coll	ege (1-4 or 5+) 12	Highw	ay Dispat	tcher		State of	Maryland
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than unatic event, the Medical		17. Father's Name (First, Middle, Last)			18		(First, Middle, Ma	ŕ	
212' vuld be Mental marke	To Be	John Wilkins Jr. 19a. Informant's Name/Relationship (Type, Prin	1)	19b, Mailing	Address (Street e	Dorothy and Number or R		SON er, City or Town, State	e, Zip Code)
MD nd 2 sho alth and alth and arm 27 is		John Wilkins, Jr. 20a Method of Disposition	(father)		Maryland			, MD 21122 20c. Location - City or	Town State
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is m injury or other fraumatic.		1 Burial 2 Cremation 3 Remo	oval from State	crematory or other		Feb			, MAryland
Saltinemit. I separtm mports	- 1	21. Son- ure of Funeral Septice)Licersee	7	22. Na	me and Address o	f Facility		Funeral H	ome. P.A.
Physician	-	23a. rant. Enter the disease, or complications failure. List only one cause on each line.	t caused the death.	Do not enter the	1 Mounta mode of dying, su	in Rd F uch as cardiac or	asadena respiratory arres	MD 21122 , shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Compl	cations of Chron		n				Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b.	r as a consequence of	n:					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	r as a consequence of	ŋ:					
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	Medical	UNPENDED AMEN	yes, outcome of pregr	nancy				23d. Date of deliver	,
Box 68760, s death certificate be execut the attending physician and d for use as the burial - tra	Physician/Me	23b. Was decedent pregnant in the	Live birth Pregnant at time of dea	2 Feta	ol death 3	Ectopic pregna	ncy		Day Year
Box e death the atte	hysic	1 Yes 2 No 9 Unknown 9	Jnknown	J Our	er (Specify)				
of Vital Records, P.O. Boing Physician: The law requires that the deald After this certificate has been signed by the att timeral director, page 2 should be detached for	<u>a</u>	Part II. Other significant conditions contributions Hypertensive Atheroslerotic Care	_	_	derlying cause giv	en in Part I.	23e. Did tob	acco use contribute to 2 No 3 Prol	the cause of death? Dably 4 Unknown
rds, require been si hould b	eted					-	24a. Was ar autopsy		stopsy findings available completion of cause of
Reco	Completed			_			perform	ned? death?	
ion of Vital Rectending Physician: The leath. The There this certificate the funeral director, page	a	25. Was case referred to medical examiner? Hospital:	Inpatient 2	ER/Outpatient		Death (Check of		esidence 6 🗸 Othe	r Scane
n of Vita ding Physicis h. After this co	2		Date of Injury (Month, Day, Year)	28b. Time of Inj				ow injury occurred	. occinc
	atio	1 Natural 5 Pending 2 Accident Investigation				s 2 No	206	and Museline or Di	ıral Route Number, City
	Certification:	4 Homicide determined (Sp.	Place of Injury - At ho	ome, iarm, street	, ractory, office bull	iding, etc.	or Town, Sta		irai Route Number, City
To the Hosp within 24 hos To the Fune	Medical (29a. Certifier 1 Certifying Physician: To the Control one) 2 Medical Examiner: On the I and many control on the I		-					
FSFS	ž	29b. Signature and title of certifier		<u> </u>	29c. License r		I	29d. Date signed (Mo	
		30. Name and address of person who complete	d cause of death (Item	23a)	O.O.IVI	· - ·		February 2, 2012	-
	ate	Ling Li, MD Assistant Medical 31. Date filed (Month, Day, Year)	Examiner 900 \		Street, Baltim	nore, MD 21	223 		
Regist		FEB 0 3 2012	A. A.	harred					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2<u>012</u> Physician/ 28 2235 Walter Lee Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Joseph Richey Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 216-28-8596 Director 1 XM 2 □ F 79 Yrs 5/17/1932 MD Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1814 Harford Ave. 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

XYes 2 No
Yes, Give Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Various Jobs Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Lee Walker Gertrude Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie Mae Lewis-Daughter Ave. Baltimore, MD 21205 801 N. Milton 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Garrison Forest 2/7/2012 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LZryna disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on: Exami Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 month Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 2 🗌 No 1 Yes 26. Place of Death (Check only one)

Ph_sician/ Medical **Examiner**

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Baltimore, Maryland 21215-0036

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Division

Hospital or Attending Physician:

items 2

attending physician and for use as the burial-tran been signed by the s should be detached cate has by page 2 s funeral director,

Be ဂ္ Certificate: within 24 hours after deat

To the Funeral Director:
completely filled in by the

Medical

25. Was case referred to medical examiner? 1 Yes 27. Mann of Death

1 / Natural 2 Accident 3 Suicide

4 Homicide 29a. Certifier

(Check

29b, Signati

5 Pending Investigation Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

arrounded the time date and clare, and due to the named and manner as state 29d Date signed (Month, Day, Year)) an 29, 2012 Ame, \$52 (to, MOD1210-1303)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of ed cause of death (Item 23a) (Type, Print) person who come

Gertitying Nurse Fractitioner: To I

and title of

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DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 28/201 9:03 Αм Annabelle Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2221 Aiken Street Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/12/1927 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 243-34-9276 1 □ M 2 **X** F Director S.C. Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director N/ABaltimore 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 2221 Aiken Street 21218 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) <u>12t</u>h Foster Care Parent Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ruben Lindsay Bessie Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Williams- Son 1031 Lenton Ave. Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2012 OwingsMills 21. Signature of Funer J Service License 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -Physician/ Conges disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 30 years Hypertenton Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the burial-transi and Due to (or as a consequence of) resulting in death) Last signed by the attending physician id be detached for use as the buria Physician/Medical **Hospital or Attending Physician:** The law requires that the death certificate be eath hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Blood 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No this certificate has been sireal director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 28d. Describe how injury occurred work? 1 \sqrt{Yes} 2 \sqrt{No} 1 Natural injury 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner To the best of my knowledge death 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Date filed (Month, Day, Year)
FEB U 3 2012

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Balto.

Division of Vital Records, P.O. Box 68760

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	for State		State of Ma	aryland			Health and N	/lental Hy	giene		
	Registrar	ne (First, Middle, La	ret)		Cer	tificate of L	Death		Reg. No.	2012	2, 02877
Physician/			Vilson					2. Date of De Month Januar		2012	3. Time of Death
Medical Examiner	4a. Facility Name (i	r Location of Death	Joanaar		ounty of Deat						
1	3209 Jan			Silver				ntgome			
Funeral Director	5. Social Security N 215-38-7 Usual Residence o	413	Sex IX M 2 □ F	e (In yrs. las 71	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 11	y, Year)	Cor	hplace (State or Foreign untry) hington, D.C
show dat tor	10a. State	10b. County	_	10c. City,	Town or Loc	ation					10d. Inside City Limits
ne Maryland or 28a-f sho c notified at Director	FL	Jackson		Alfo	ord						1 🗌 Yes 2🗶 No
ith the	10e. Street and Nu	tek Blvd.				10f. Zip Code			-	en of What Co	untry?
items 23a er must be	11. Marital Status	LEK BIVU.	12. Was Decedent E	ever in U.S.	13. V	32420 Vas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	USA	. Race - Ame	rican Indian
fter de amine	1 Never Mar	ried 2 Married	Armed Forces? 1 ☐ Yes 2X☐ If Yes, Give	No		Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)		Black, White	· ·
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nd 2 sho ealth an m 27 is ier traui			Phipps/daug	hter	19b. Mailin	g Address (Street) Janet Roa	and Number or Rura ad Silver	Spring	r, City or To MD	wn, State, Zip 20906 	o Code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director			Removal from State	ce	metery, crem	sition (Name of eatory or other place	natory 02/	Date /02/12		ation - City or Dine, M	
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Physician/ Medical	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	(Final on	plications that caused one cause on each line a. Alcohol	ic En	cepha.		g, such as cardiac c	or respiratory and	rest,		Approximate Interval Between Onset and Death
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at the death certificate be by the attending physici etached for use as the bu bysician/Medica	in the past 12 1 Yes 2 1 9 Unknown	□ No	4 Pregnant at 9 Unknown			Other (specify)	. , ,			Month	Day Year
s that th gned by be detac by Ph	Part II. Other signi	ficant conditions	contributing to death be	ut not resul	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
uld be	· -							1 🗆	Yes 2 🗆	No 3 ☐ Pr	obably 4 Unknown
The law require cate has been si page 2 should I								24a. Was		24b. Were aut	copsy findings available
Physician: The law rethis certificate has aral director, page 2									rmed?	death?	2 🗆 No
certifi rector.	25. Was case referr examiner?	red to medical	Hospital:			Oth	ace of Death (Check				daughter's
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endin sath. or: Afte he fun	1 Natural 2 Accident	5 ☐ Pending Investigatio		, rear)	injury	M 1 🗆	Yes 2 No				
after death. Director: After t in by the funera	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not to determined	28e. Place of Inju building, etc		ne, farm, stre	et, factory, office		28f. Location (S City or Tow		lumber or Rur	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical	(Check 2	🛚 🔛 Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	camination a	and/or investi	gation, in my opinic	on, death occurred at	the time, date a	ind place, an	nd due to the c	ause(s) and manner stated.
To the with To the com	29b. Signature and		18		X	29c. License	number		29d. Date s	signed (Month	, Day, Year)
101			completed cause of de			rint)				1 3.7	
State	31 Date filed (Ment	thyppy mear)	1355 Piccar	rd Dr	ive Ro	ckville,	MD 20850)			
Registrar	FEBU 3	ZUIZ Com	32. Registra	19 60							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:00 PM Joyce White Jan 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brook Grove Nursing Home Sandy Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** 06/26/1932 Months Hours 1 🗆 M 2 😾 79 474-30-0610 Minnesota **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 28a-f Silver Spring 1 Yes 2 X No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral 14805 Pennfield Circle #212 20906 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify If Yes. Give Year or Dates. 1951-52 Specify: White 'natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o ည Sundvick Russell Hildur Westberg Ellen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 Department of Health Important: If item 27 Lisa Miller / Grand Daughter 620 Trixsam Rd., Sykesville, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2XXCremation 3 Removal from State 02/01/2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) injuny Signature of Funeral Service Licensee MO1585 Rapp and Address of Facility Cremation Services He Deces 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEEKS Immediate Cause (Final Physician END STAGE RENAL FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FFMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Month Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ឺ Unknown THROMBOTIC THROMOCYTOPENIC PURPURA, ANEMIA, DEMENTIA 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed?

1 Yes 2X No as 2 1 Ves 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: AXX Nursing Home 5 A Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1 X Natural work? 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 24 hours after death Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number

20+1

State Registrar ANURADHA

ARUN

3 2012

M. D. 10301 GEROGIA

32. Registrar's Signature

10301 GEROGIA AVE.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

D57630

#209, SILVER SPRING, MD

February 1, 2012

20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Brittany Ann Walker	State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		Certificate o	f Death		F	Reg. No.	
Physicia		Decedent's Name (First, Mid	dle,Last)				Date of Dea Month		3. Time of Death
al Examii		Brittany A. W	alker				January 2	Day Year 28, 2012	0335 hrs
		4a. Facility Name (if not institut	ion, give street and number)		4b. City, Town, or	Location of De		4c. County of Dea	ath
		Rt 50 EB Mile post 1	8		Davidsonvil	le		Anne Arunde	el
Funeral	-	5. Social Security Number	6, Sex 7. Age (In	yrs. last birthday)	If Under 1 Yea	r If Under 24	Hrs. 8. Date of B	irth (MM/DD/YYYY) 9. E	Birthplace (State or
Director		214-37-9026)	Months Day	s Hours	Min. Sant	20, 1992 For	eign Country) MD
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	- 1	Usual Residence of Decedent	400	. City, Town or Loca	tion				10d. Inside City Limits
y any		10a. State 10b. Count	1		tion				1 Yes 2 XNo
pu ogs	5	MD Anne	Arundel Ha	anover					T Tes 2 XINO
or 28a-f show	\$	10e. Street and Number			10f, Zip Code			10g. Citizen of What Co	
he N	Director	7670 Ridge Ch	apel Rd.		21076			United Sta	ates
eath with the items 23a ust be noti		11. Marital Status	12. Was Decedent Eve	r in U.S. 13. W	as Decedent of His	spanic Origin?	(Specify Yes or N		erican Indian, Black,
ath ath	Funeral	1 X Never Married 2	Married Armed Forces?		Yes, specify Cubar	n, Mexican, Pu	erto Rican, etc.)	White, etc.	•
er de		3 Widowed 4 D	1 Yes 2 X Divorced If Yes, Give Yeer	No 1	Yes 2 X No	specify:		Specify: W	hite
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36 Iical	픮	12	., Johnson	Stude	nt			Education	,
With with Mer ti	E	17. Father's Name (First, Midd	lle 1 eet)	bedde		18 Mother's N	ame (First Middle	Maiden Surname)	
filed filed of		Michael N. Wa	•			Ann M.		, , , , , , , , , , , , , , , , , , , ,	
21215-0036 hould be filed within 72 hours aftered Montal Hygiene. is marked other than "natural", it creen, the Medical Examiner.	B	19a. Informant's Name/Relatio		10h Mailir	a Address (Stra			ımber, City or Town, Sta	ate Zin Code)
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. a 27 is marked other than umatic event, the Medica	읟								
M 27 m 27	J		/ Grandfather	20b. Place of Dispo			Date	ver, MD 210	
r f Hee		20a. Method of Disposition	ion 3 Removal from State	crematory or o			'eb. 4	Zoc. Location - Ony	or rown, outo
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland neptot fleath and Mental Hygiene. Instit If item 27 is marked other than "natural", or items 23a or 23a-f shoor or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other		Meadowri	dge Mem.		2012	Elkridge,	, Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	- 1	21. Sig aturn Fune Servi		22.	Name and Addres	s of Facility	D 1	Home, P.A.	
Life Den Co	- 3	141 2/W.	X	K.	irkley-Ri 21 Crain	Hwv	Funeral S.E. Gle	n Burnie, N	MD 21061
hysician			or complications that caused the	death. Do not enter	the mode of dying	, such as card	iac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
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760, cate be execut physician and he burial - tra	Medical	UNPENDED	AMENDED						
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Box 687 e death certifithe attending of for use as the	/si	1 Yes 2 No 9 🗸		3 🗀 (other (Specify)			i i	1
the ched	Physician	Part II. Other significant con	ditions contributing to death bu	t not resulting in the	underlying cause	given in Part I	23e. Did	tobacco use contribute	to the cause of death?
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ian: The certificate ector, page	Be C	25. Was case referred to med		6.2	26.Plac	e of Death (Ch			
Vita ysici his o	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Other N	lursing Home 5	Residence 6 🗸 0	ther: Scene
of Vital Records, g. Physician: The law requir offer this certificate has been so neral director, page 2 should the state of the state	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jan 28, 2012	28b. Time o	f Injury 28c. Inj	ury at Work?		e how injury occurred o auto collision	
on ath.	ᅙ		ending	0331 hrs	1	Yes 2 V N	o Diversion	o dato combion	
Division tal or Attendia rs after death. al Director: A led in by the fu	<u>E</u>		ovestigation 28e. Place of Injury	- At home, farm, str	eet, factory, office	building, etc.			Rural Route Number, City
Div pital or ours afte reral Div	Certification:			Road / Highwa	ау		Rt 50 EB M	ile post 18, Davidsor	nville, MD
Hosp 4 hou Fune			Physician: To the best of my kr	nowledge, death occ	curred at the time, o	date and place	, and due to the ca	use(s) and manner as	stated.
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Runeral Director: After this certificompletely filled in by the funeral director;	Medical		Examiner: On the basis of examin and manner stated.						
SHEE	Š	29b. Signature and title of cer		1	29c. Licer	nse number		29d. Date signed ((Month, Day, Year)
		1011	1116	4	0.0	M.E.		January 28, 26	012
		30 Name and address of per	son who completed cause of deat	th (Hem 23a)				1	
		Zabiullah Ali, M.D.	Assistant Medical Exar		Baltimore Str	eet, Baltîm	ore, MD 2122	3	
				Signature					OCM E
S	tate	31. Date filed (Month, Day, Ye	L Busines B.	ANGEL STATE					UGITTU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wishara 20/2 : 254M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayujew Care Center timore N/A 8. Date of Birth
June 18, 24 9. Birthplace (Sta If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex 1.□ M 2 🔏 F **Director** 214-22-6518 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a State 10h County 10c. City, Town or Location **Funeral Director** 1 X Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? United States 21230 2547 Marbourne Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Home Maker Own Home Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>trance.</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Gribben Laura (Jenkins) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $6012\ Adcock\ Lane,\ Hanover,\ Maryland\ 21076$ Michael Folger / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 2/04/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Faneral Service Licens Name and Address of Facility Ambrose, Funeral Home, Inc. 1327 Sulphur Spring Rd., Arbutus, MD 21227 alin and David 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ congestive disease or condition resulting in death) 41003 Medical Examiner cronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events pue to for as a consequence of Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records,

State Registrar (Check

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D33316

Hipkins Bayerer Circle Baltimure MD 2/224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TEM#4a, b, per CNP, G924, 27372012, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti 01 23^{Day} Charles Leslie Wright, Jr. 20°12 4:30 P Medical Facility Name (if not institution, give street and number)
5722 Utrecht Rd.
Gilehrist Hospice 4b. City, Town, or Location of Death
Baltimore
Towson **Examiner** 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months 1 X M 2 □ F Hours Min 09/25/1937 Country) MD Director Vrs 213-34-4767 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S. 21206 5722 Utrecht Rd items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status marked other than "natural", or iter matic event, the Medical Examiner 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Black, White, etc. Yes 2 No Yes, Give Completed by within 72 hours after 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Company Sales Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ sarah Ellis Charles Leslie Wright, Sr. Page 1 and 2 should I nent of Health and Mc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Phyllis Ann Wright - Wife 5722 Utrecht Rd., Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of 01/27/2012 Donation 5 Other (Specify) Baltimore, MD Moreland Mem. Park 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Miller-Dippel Funeral Home, Ve. auro 6415 Belair Rd., Baltimore, MD 21206 23a. Part 1. En a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (His a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year be detached 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician; The Is within 24 hours after death.

To the Funeral Director; After this certificate to performed? Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2**X** No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 was

Registrar DHMH 17 Rev 7/2009

15+1 v

Box 68760

P.O.

Records,

of Vital

Division

6701 N. Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Ma		epartment of		Mental H	2	010	0200
	Physic	ian/	1. Decedent's Name (First, Middle,	,		Oct timeate of	Death	2. Date of D		UIC	3. Time of Death
	Med Exam	ical	Robert Willia 4a. Facility Name (if not institution, g					Month 2	Day	Year 2012	1104 AM
	Exam	ii ier	FRANKLIN SQU		To. I		or Location of Death 205eolo.1	e		y of Death	44.5.4.5
-	Funera		5. Social Security Number 6		(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Birthr	olace (State or Foreign
	Directo		218-16-1074 Usual Residence of Decedent 10a. State 10b. County	1 🕅 M 2 🗆 F		rs. Months Days	Hours Min.	May 16	9ay, Year) 5,1925	Coun Ma	ryland
	arytar la-fsh	Funeral Director			10c. City, Town					1	0d. Inside City Limits
	the M or 28 e noti	ä	10e. Street and Number	Balto.		Roseda 10f. Zip Code	<u>le</u>		10.00		1 Yes 2 No
	s 23a	hera	9583 Shirewood	Court			21237		10g. Citizen of	What Coun	itry?
1-	death r item		11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of I If Yes, specify Cub		cify Yes or No		ce - Americ	an Indian,
در 336	after al", o	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No. If Yes, Give Year or Dates. 19	0			rican, etc.)	Bla Specify	ck, White, e	ite
1206er 215-0036	hours natur dical B	Completed	15. Decedent's	Education		Decedent's Usual Occur					
22.52	nin 72 ne. han " e Mec	l mo	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4 or 5+)	(Give kind of work done fe. DO NOT use retired	during most of worki	ng	16b. Kind of B	lusiness/Inc	lustry
² 22	d with tygien ther t	Be C	12th			ectrician			Steel (Compai	ny
Maryland	be file antal F ked or	일	17. Father's Name (First, Middle, Las John Williams	t)			18. Mother's Name			e)	
aryle	nd Me		19a. Informant's Name/Relationship	(Type Print)			Mamie N				
ि। त् e, Mar	d 2 sh alth ar 1 27 is er trau	١.	Mary Williams		- 1	Mailing Address (Street					
Wil more	of He of He fitem		20a. Method of Disposition	Spou	20b. Place of D	9583 Shires Disposition (Name of		Ros	edale Mo		
₩ 1	. Page ment tant: I		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State cify)		crematory or other place anislaus	2-4-2	2012	Balto.	•	, state
Bali	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee		22. Name and Addre	ss of Facility Mil		ppel Fur	neral	Home, Inc.
	202 (0)		23a. Part 1. Enter the disease, or co	elle			Lair Road		o.Md. 21	206	
	Ph_sician/ Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	one cause on each line.	onsequence of):	inface					Approximate Interval Between Onset and Death
09	ate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last								
	irtifical ling ph	/Mec	IF FEMALE;								
). Box 687	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transi	hysicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin 9 Unknown	Fetal death ne of death	3			23d. Dat Mor	e of deliver	y Day Year
Э.	s that gned be de	by F	Part II. Other significant conditions	contributing to death but n	not resulting in th	ne underlying cause giv	en in Part I.	23e. Did to	obacco use contri	bute to the	cause of death?
rds	equire een si nould	ted						1 🗆 '	Yes 2 No	3 🗌 Proba	bly 4 Unknown
Division of Vital Records, P.O.	The law rate has b	Completed						24a. Was a	psy p	Vere autops rior to com eath?	y findings available pletion of cause of
a H	an: Th tifficat tor, po	BeC	25. Was case referred to medical	1		ae Di-		1 🗆 Yes		Yes 2	□ No
<u>X</u>	hysici nis cer I direc	일	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpa	tient 3 DOA Othe	r: 4 Nursing Hom		0 T 0"	(0)	
o of	ing P		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Ye	28b. Time	of 28c, Injury	at 28		ow injury occurre		
sior	ttend death stor: A the 1	Certificate:	2 Accident Investigation 3 Suicide 6 Could not it			M 1 🗆 '	Yes 2 No				
Divis	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		4 Homicide determined	building, etc. (S	pecify)		- 1	City or Tow			
	the Hos thin 24 h the Fun mpletely	Med	only one) 3 Certifying Nur	rsician: To the best of my liner: On the basis of examingse Practitioner: To the best	knowledge, deat nation and/or inv st of my knowled	th occurred at the time, restigation, in my opinior ge, death occurred at th	date and place, and n, death occurred at the e time, date and place	due to the car ne time, date ar e, and due to th	use(s) and manne nd place, and due ne cause(s) and ma	er as stated. to the cause anner as sta	e(s) and manner stated.
	S N N N	2	9b. Signature and title of certifier			29c. License	number		29d. Date signed		
		-	10. Name and address of		crehent	100	71830		Feb 1	20	12
	100		0. Name and address of person who	completed cause of death	(Item 23a) (Type		in Sm.	0 1 - 1		1 1 - 11-	12122
	Stat	e 3	1. Date filed (Manth: Pay Year)	32. Redistrar's		INMINISC	in Sau	ave L	1K ISal	10, m	a 21237
	Registra	r	730								

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 **Physician** 6:50 AM YORK HILARY ANN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. 1 □ M 2 🛣 F Director 215-50-7668 52 12/14/1959 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evantral must be notified at 1KNYes 2 □ No Directo N/A MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3421 KESWICK ROAD, APT. A 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify. <u>ک</u> Specify: 3 ☐ Widowed 4 🌠 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item Z7 is marked oth any lolly or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ YORK SHIRLEY RESNICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELENIE YORK/SISTER 4630 SCHENLEY ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CARROLL CREMATION INC 02/03/2012 4 ☐ Donation 5 ☐ Other (Specify) HAMPSTEAD, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** severe SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 X Yes 2 □ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Taleli On MD AT2438946 1/30/12 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ebrahim Talebi Quje 1201 east university PKWY-Baltimore 121218 31. Date filed (Month, Day, Year) 32. Registrar's Sinature

DHMH 17 Rev 1/2001

State

Registrar

FEB 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ urcik arruare Illiam 04-AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore onns cial Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **Director** 085-24-1826 1XXM 2 □ F 80 Yrs. Aug. 1, 1931 New York Usual Residence of Decede iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? Funeral 213 Bentley Hill Drive 21136 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
A.M. Yes 2 No 1948—
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify. and Mental Hygiene. Completed 3 Widowed 4 Divorced Specify: 1960 White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul Yurcik Sophia (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary L. Yurcik (Wife) 213 Bentley Hill Dr., Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important: If ite 20c. Location - City or Town, State emetery crematory or other place) Faiths Crematory & Chapel 1 Burial 2XX Cremation 3 Removal from State ${\tt Alf}$ 4 Donation 5 One (Specify) 2012 Manchester, Maryland Signature of Funeral Survice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 The thren the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause pn each line. Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE ART disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and I-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? perform 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၀ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 290 Signatur 29d. Date signed (Month, Day, Year) n who completed cause of death (Item 23a) (Type, Print) 10×1 V WOL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		/ Depa		t of H	lealth		•		20	112	02885	
	Physicia		1. Decedent's Name (First, Midde Catherine Ma:						2. Date of D Month 01	eath)ay 29	Year 2012	3. Time of Death			
E. Ja	Medic Examin		4a. Facility Name (if not institution	on, give street and number)		4b. City,	Town, or	Location	of Death	0.1	4c. County of Death					
أبر			Stella Maris 5. Social Security Number	10.0			Timonium If Under 1 Year If Under 24 Hrs. 8, Date					Baltimore				
	Funeral Director		213-30-0463	6. Sex 7. Age	birthday) Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, L	Day, Year,	irth 9. Birthplace (State or Foreign Country)				
			Usual Residence of Decedent 10a. State 10b. Coun								04/10/	1929	9		yland	
	arylanda-fish	Director		timore	10c. City, To	own or Loc imore								1	0d. Inside City Limits 1 Yes 2 No	
	filed within 72 hours after death with the Maryland Hygiene. 4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.		10e. Street and Number 4627 Asbury				10f. Zip	Code 1206				10g. (Citizen of USA	What Coun		
	leath wi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W			spanic Ori	gin? (Spe	cify Yes or No Rican, etc.))-		ce - Americ		
036	s after or ral", or Examir	ed by	1 X Never Married 2 M 3 Widowed 4 Divorce	arried 1 Yes 2 🔀	No		Yes 2				riicari, cic.,		Specify	ck, White, 6		
2-C	2 hour "natul	plete		lent's Education hest grade completed)	1	6a. Deced	ent's Usua rind of wor	l Occupa	ation	t of worki	na	16b.	Kind of B	lusiness/Ind	dustry	
77.7	within 7. giene.	Completed	Elementary/Secondary (0-12		+)	life. DC	NOT use	retired)				Mei	n's (Cloth:	ier	
Baltımore, Maryland 21215-0036	be filed of the sental Hygrephysic event, ic event,	To Be	17. Father's Name (First, Middle	, Last)							e (First, Middl			e)	-	
ar Ži	12 should be file lith and Mental H 27 is marked o r traumatic eve		Charles Yost 19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	a Address	(Street a			ie Grie I Route Numl			State, Zip C	Code)	
Ξ	and 2 sh Health a tem 27 is		Edward Lawre	nce - Nephew			_				imore					
nore	age 1 and 2 ant of Healt it: If item 2 y or other 1		20a. Method of Disposition 1 X Burial 2 Crematic	n 3 Removal from State	ceme	e of Dispos etery, crem	atory or of	her place			Date			- City or To		
alti	permit. Page 1: Department of I Important: If its any injury or of		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Septice		ватт	imore					./2012 .ler-Di					
ñ	a III De		Trues	Sur		64	15 B	elai	r Rd.	, Ba	ltimor	e, l	4D 2	21206		
23a. Part 2 Enter the disease, or confplications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one of line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a consequence of):											Interval Between					
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	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С												
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	certificate to adding physuse as the			d												
o n	death ne atte ed for	by Physician/Med	FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1									23d. Date of delivery Month Day Yea				
ds, r.o.	quires that t en signed b ould be deta	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death				
Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after desired. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed										4a. Was an autopsy gentormed? Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
<u> Ta</u>	siciar s certif directo	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 ER/	/Outpotion	. a □ no	Othe	r: 4 Day		me 5 Re	-1-1		(0		
0	ng Phy ter this meral o	te: T	27. Manner of Death	28a. Date of injur	y 281	b. Time of injury		Bc. Injury work?	at		28d. Describe					
lo l	tendir death. tor: Af the fu	2 \[\text{Accident} \] Investigation \[\text{M} \] 1 \[\text{Yes 2} \[\text{No} \]														
DIVISION	al or A s after al Direc ed in by		4 Homicide deter	mined 28e. Place of Inju building, etc		, rarm, stre	et, factory,	опісе			281. Location City or To			er or Hural	Route Number,	
	P Hospi 24 hour Funera etely fill	Medical	(Check 2 L Medical	ng Physician: To the best of r Examiner: On the basis of ex ng Nurse Practitioner: To the	amination an	ıd/or investi	gation, in n	y opinio	n, death o	ccurred at	the time, date	and place	ce, and du	ie to the cau	use(s) and manner stated.	
	To the complete t		29b. Signature and title of certifi		, sost of flig K		290	License	number	& and pla	oc, and due to	1	ate signe	d Month, L		
			30. Name and address of perso	a who completed cause of the	oth (Hora 22	a) (Time 5	rint)	ツ [・])	00-1	0		1	120	117		
6	V		Howard Goldma		,			Ba1	to. N	Md. 2	21237					
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	riegistra	.,	1118													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental / Department of Health And Mental / Department of Health And Mental / Department of Health And Mental / Department of Health And Mental / Department of Health And Mental / Department of Health And Mental / Departme For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Esmeralda V. Adams 0330 anuar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Meritus Medical Center Washington County Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days April 26.1930 Hours Pennsylvania 196-28-9610 Director 1 □ M 2 🗓 F 81 or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director PA Schuylkill Pottsville 1 X Yes 2 No 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ms 23a or must be n Funeral 605 Mine St. 17901 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White "natural" Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other than Owner/Operator Pizza Shop Be Julid 2 should be file of Health and Mental Hy tem 27 is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic Vittemberghi Julia Celani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark R. Adams 615 Mine St. Pottsville, PA 17901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Department of Importants If any injury or once. Magdalene Crematory | 1-21-2011 4 Donation 5 Other (Specify) Ringtown, PA 21. Signature of Funeral Service 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line Rib and Hip Fractures with Complications 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 1 noumon A disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** - OBSTAYERVE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes ∠ ∟ 9 ☐ Unknown g | Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYD SATENS, ON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? ALICHSO MONTE 24a. Was an this certificate has Chronic Obstructive Pulmonary Disease performed 2 🗌 No Yes 2 N 1 TYes Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 110 Other: <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Subject fell 28c. Injury at the Hospital or Attending 01/01/2012 5 Pending Unknown a 2 X Accident and Subject fell out of bed 1 Yes 2 X No Investigation 01/04/2012 Unknown Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 605 Pine St., Pottsville PA, 1116 Medical Campus Rd, Hagerstown, MD determined **Hospital** and Home within 24 hours a To the Funeral D Medical 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALITAG -WILSON 11116 MSDICAL CAMPAUS RD GATY SUSTON Mayon tospina-

DHMH 17 Rev 06-2011

State Registrar 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 25.629d per med cert 6924 2/7/12 dk
State of Maryland / Department of Health and Mental Hygiene

			State Registrar	Ce	ertificate of l	Death	Reg	. No. つ	0 02887				
п	Physicia	in/	Decedent's Name (First, Middle, Last) Lena Orpha Adkins				2. Date of Death Month	Day - Year	3. Time of Death				
Medi- Examir			4a. Facility Name (if not institution, give street and number)		4b. City. Town, o	or Location of Death	January	15, 2012 Year 4c. County of Dea	2:07 P M				
7			Chesapeake Shores		Lexingt	ton Park		St. Mar					
	Funeral Director		1 DM 0 X I E	93 Yrs.	Months Days		8. Date of Birth (Month Day Ye April 9,	9. Bi	rthplace (State or Foreign puntry) L rginia				
	yland f shov ed at	ğ		. City, Town or L	ocation				10d. Inside City Limits				
	e Mar r 28a- notifie	Direc	Maryland St. Mary's 10e. Street and Number			ngton Park			1 ☐ Yes 2 🔀 No				
	ath with the sms 23a o	Funeral Director	21263 Joe Baker Court 11. Marital Status 12. Was Decedent Ever in	118 112	10f. Zip Code	20653			SA				
9800	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 XX Wildowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates.		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ican, etc.)	14. Race - Ame Black, Whi					
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, Ma	ge 1 and 2 should be it of Health and Mer If item 27 is marke or other traumatic		Janet J. Shoemaker/ Daughter			and Number or Rural I estown Oak							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 si Department of Health a Important: If item 27 i any injury or other tra		20a. Method of Disposition	comotoni oro	position (Name of ematory or other place -Gardiner me.P.A.Crema	Da atory 01/17/		c. Location - City or	r Town, State				
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	2	22. Name and Address Mattingle 41590 Fen	ss of Facility Ey-Gardine Wick St.	r Funeral Leonardi	L Home, P	20650				
ينسر	Ph __ sician/	8 0	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St. Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Onset and Death										
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). Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify)	sy		23d. Date of de Month	elivery Day Year				
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Division of Vital Records,	Physician: The law re r this certificate has be aral director, page 2 sh	Completed					24a. Was an autopsy performed	prior to death?	ntopsy findings available completion of cause of				
Vita	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	□ EB/Outpotio	Otho	ace of Death (Check of							
of	ding Phy th. After this funeral o		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year)	28b. Time of		/ at 28	e 5 ⊔ Residence d. Describe how in	6 Other (Special of the object)	cify)				
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		}	30. Name and address of person who completed cause of death (It	tem 23a) (Type, I	Print)	000/		nuary 15					
(5	pme		Tennifer Schmidt Do 40900 31. Date filed (Month, Day, Year) 32. Registrar's Sig	Merch	ants lane	Suite 205	Leon	ratown	MD 20650				
	State Registra		JAN 18 2012 Anna		ale								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harold Raymond Andrus, Jr. 2012 5:55 Medical <u>January</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 **X**] M 2 □ F Months 07/20/1924 87 Michigan Director 367-18-1216 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Prince Georges College Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 3509 DePauw Place 20740 U S A hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Officer United States Navy Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic o Harold Raymond Andrus Clara Schaible 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Andrus/Wife 3509 DePauw Place, College Park, MD 20740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State cemetery, crematory or other place) rinsfield-EcholsCrem; 1/17/2012 4 Donation 5 Other (Specify) Charlotte Hall, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death + Lower Lobe Pricumonia Immediate Cause (Final Physician/ disease or condition Juluk Medical resulting in death) Examiner -UKEMI1 one port Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last arending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death signed by the a endir 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed ANTIMIA 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s CAIRONIC OBSTRUCTIVE PULNOMORY autopsy performed? Yes 2 No DISEASE death? 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Tes 2 🗌 No 24 hours after death. Funeral Director: A Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hore To the Fune completed fi (Check Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Stephen P. Cafferty, M.D. 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622

31. Date filed (Month, Day, Year,

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 21 2012 3:20 Robert Lee Benner, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12021 Mayfair Avenue Washington Hagerstown Social Security Number 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Oct. 10, 1939 Hours **Director** 214-36-1306 Usual Residence of Deced 1 MM 2 □ F 72 Mary1and 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? Funeral 12021 Mayfair Avenue 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Barber 9 Barber and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic e Arthur Benner other traumatic Martha Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Benner / Spouse 12021 Mayfair Ave., Hagerstown, MD 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 1/25/2012 Hagerstown, Maryland 21. Signatur Funeral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence of Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months? Day Year Pregnant at time of death the i Yes 2 No g Unknown g Unknown ed by the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Xes 2 No 3 Probably 4 Unknown should Completed 24a. Was an Were autopsy findings available prior to completion of cause of Jas autopsy page 2 certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. Nirector: After the in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n. 24 hour. Funeral Dir. Yifilled in bv 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 2

To the F

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29b. Signature

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d, Date signed (Month, Day, Year)

anuary 23, 20

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************			Reeders Memorial Home 5. Social Security Number 16. Sex 17. Age (1)	In yrs. last birthday)	Boonsboro If Under 1 Year If Under 24 Hrs.	O Data of Blath	Washing			
	Funeral Director		207-03-5065 1 \(\text{M} \) 2 \(\text{X} \) F 7. Age (i)	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo April 15	ear) Co	thplace (State or Foreign buntry)			
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	yland •f sho ed at	ctor	10a. State 10b. County 1	Oc. City, Town or Loc	eation			10d. Inside City Limits		
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တ္တ	fter de , or it	by F	1 Never Married 2 Married Armed Forces?		Yes, specify Cuban, Mexican, Puerto I Yes 2 X No Specify:	Rican, etc.)	Black, Whit	e, etc.		
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ta	spital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director,	Be	25. Was case referred to medical examiner? Hospital:	20 <u>1, 12</u> 66	26. Place of Death (Check		(V - V - V - V - V - V - V - V - V - V -			
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Division of	tal or rs afte al Dir ed in		building, etc. (Specify)		City or Town, S	State)			
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	To the Hosp within 24 ho To the Fune completed f	Ĭ	only one) 3 L. Certifying Nurse Practioner: To the be 29b. Signature and title of certifier	st of my knowledge, d	leath occurred at the time, date and place		use(s) and manner as d. Date signed (Mont			
	FSFÖ		M Cledw > m D		DELLEZI	-	7mm 19,	2012		
	1		30. Name and address of person who completed cause of dea	th (Item 23a) (Type, P	rint)	,	3	51. 432.8470		
_	IN-15		Dr. Gmzala Oadir á	20311 L	appans Kd. Be	2005 Der	o MD	21783		
	Stat Registra		31. Date filed (Month, Day, Year) 32. registrar's	Signature	and the state of t	-IIe				
DH	MH 17 Rev 7/20	-	The same of the sa	P. 190						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Lewis Broun January 11:24 PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 12001 Ashley Drive Rockv111e Montgomery 8. Date of Birth (Month, Day Yea Sept. 21, . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F 80 Year 1931 Washington, DC 579-40-9311 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Montgomery Rockville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12001 Ashley Drive 20852 death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 X Married TXXYes If Yes, Give 72 hours after Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. If Yes, Give Korean Year or Dates Confiict Completed 3 Widowed 4 Divorced other traumatic event, the Medical 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman <u>Insurance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Marion Broun Cathern Agnes Morgal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary Catherine Broun/Wife 12001 Ashley Drive, Rockville, MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 € Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) n. 23 2012 Jan. 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 2 yrs. Immediate Cause (Final Physician/ Lung Cancer disease or condition yrs. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year ed by the a g Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 🗌 Yes ᄵ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif

State Registrar George Sotos, MD

2 0 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43083

9707 Medical Center Drive, #300, Rockville, MD 20850

Jan. 18, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2012 7:00 A.M January Edward <u>Charles</u> Barton Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring 12205 Dewey Road 8. Date of Birth 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthdav) Funeral Days Months Hours (Month, Day, Year) an. 26, 1967 1 🛛 M 2 🗆 F Maryland Jan. **Director** 579-88-1838 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Silver Spring Montgomery Maryland| 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral United States 20906 12205 Dewey Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces Yes 2 No 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Self <u>Employed</u> Plumber 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda L. Brigham Barton Everett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12205 <u>Dewey Ro</u>ad, Silver Spring, Maryland 20906 Laurie Bennington/Fiance 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Derwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2012 cketts Cemetery 22. Name and Address of Facility DeVol Funeral Home Sign ture of Funeral Service I 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GALRY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 \square No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 X No ... une Hospital or Attending Physician: The la within 24 hours after death.

To the Funeral Director: After this certificate has condited filled in by the funeral director. page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Manish Agrawal, 31. Date filed (Month, Day, Year)

JAN 20 32 Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

D 62234

9707 Medical Center Drive, #300, Rockville, Maryland 20850

January 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GORDON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Tate Chesapeake Hospice House Linthicum Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Min 405-38-6896 82 **Director** 1 M 2 □ F June 11,1929 Kentucky Usual Residence of Deceden 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 W. McKinsey Road Apt. 315 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Director of Clinical Lab Healthcare/ Hospital Be th and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sevier Franklin Bell Joel Pitchford Avice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Andrea Weir / Daughter 535 Devonshire Court Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot January 1 XBurial 2 Cremation 3 XRemoval from State Calvary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Lexington, KY 2012 Signature of Emeral Service Licenses 22 Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** lan Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and -trai Due to (or as a consequence of): physician a Physician/Medical Box 68760 as attending ' IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page this certificate 1 Yes 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) THIE Hospital: 2 No Other: ည 1 Yes HOUSE 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After pletely filled in by the fur 1 Yes 2 No Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Leavilying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 162012 21438 3 DWIGW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAPENTAMO MD, MICHAEL 445 DEFENSE MIGAWAY, ANNAPOLIS 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ James H. Browning, Sr. 2012 1115 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Min. (Month, Day, Year) 80 **Director** 235-44-1775 1 X M 2 □ F 29, 1931 West Virginia Jan. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Lanham 1 Yes 2 X No MD Prince George's ō 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? items 23a Funeral 20706 7212 Sunrise Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or. þ 1 X Yes 2 No Army 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural", Completed 3 🗆 Widowed 4 🗆 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Food Service should be filed with and Mental Hygien is marked other ti Mobile Catering 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Elizabeth Lovins Hubert Browning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Drema D. Redding/daughter 826 Vacation Drive, Odenton, MD 21113 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD · Veterans · Cemetery nation 5 Oner Specify 1-23-2012 Cheltenham, Maryland ☐ Donation Cheltenham a 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last g physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 💢 No 은 1 Tes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this
completely filled in by the funeral i 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 \(\text{Yes} \quad 2 \(\text{No.} \) 1 X Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1/16/2012 068912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20904

DHMH 17 Rev 06-2011

Registrar

Amend #12 per AACO Health De				se Type or					Ensure A alth and M	-		_	•
	_	State Registrar		Otate	or warylar		rtificate o				Reg. N	0014	02895
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Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1261 CERSTNER COURT GAMBRILLS									4c. County of Death ANNE ARUNDEL		
Funeral		1261 GERSTNER COURT 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						ear If	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	rthplace (State or Foreign	
Director		460-46-4519 Usual Residence of Decedent					Months Da	,,,,,,		06/08/			
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or 28a-	Funeral Director	MARYLAND 10e. Street and Num		RUNDEL	GAI	MBRILL	S 10f. Zip Coo	de			10g. C	itizen of What C	
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0036 urs afte ural", c	ted b	3 Widowed		If Yes, Giv Year or D	2 X No ve ates.		1 ☐ Yes 2 🔀				,	Specify: WH	ITE
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and be filed ental H ked ott	To Be	17. Father's Name (F JOHN GRE		ast)				- 1	8. Mother's Nam ANN ALLI	,	, Maider	Surname)	
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", or rraumatic event, the Medical Exam	. (1	19a. Informant's Na		nip (Type, Print)		19b. Mail	ing Address (Str	eet and	Number or Rura	al Route Numbe	er, City o	or Town, State, Z	ip Code)
e, M and 2 s Health em 27 ther tr		JONATHAN 20a. Method of Disp		OBY/ SON	20h		GERSTNE osition (Name o		OURT GAI	MBRILLS Date		ARYLAND Location - City o	
Mor Page 1 ent of int: If it			X Cremation	3 ☐ Removal from	State CHE	cemetery, cre SAPEAK F.NTER	matory or other E CREMA	TIO	N 01/20	0/2012			LE, MARYLAND
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of Fur				HÊ	2 Name and A	dress c	THEWNAM	TING TR	IBN'	res _{fune} l	ELLOWSE P.A.
		23a art 1. Enter ti	he disease, or	complications that only one cause on ea	caused the dea	th. Do not en	B14_BEST ter the mode of	'GAT dying, s	E ROAD A	ANNAPOL or respiratory a	rrest,	MARYLAI	ND 21401 Approximate
Physician/		Immediate Cause (disease or conditio	Final	only one cause on e	On On	men	Xia						Interval Between Onset and Death
Medical Examiner		resulting in death)		Due to	(or s a conseq	uence of):							
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Division of Vital Records, ral or Attending Physician: The law requires s' after death. The law fare this certificate has been signed in by the funeral director, page 2 should be a more than the funeral director.	Completed									24a. Was auto perf 1 Yes	opsy ormed?	prior to death?	utopsy findings available completion of cause of es 2 \(\square\) No
fital sician: certific	To Be	25. Was case referre examiner? 1 Yes 2		Hospital:	Inpatient 2	ER/Outpatie		Other:	of Death (Chec		idanca	6 Other (Spe	on Hour
Division of Vital Rec no the Hospital or Attending Physician: The la within 24 hours after death, for this certificate ha To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	Certificate: To	27. Manner of Death 1 Natural 2 Accident	5 Pendii	28a. Date (Moi gation		28b. Time of injury	of 28c.	Injury at work?		28d. Describe			ion,y,
Divisic al or Atte s after des I Director		3 ☐ Suicide 4 ☐ Homicide	6 L Could detern	inad 28e. Plac	e of Injury - At h ling, etc. (Specia		treet, factory, of	fice		28f. Location City or To			tural Route Number,
he Hospit in 24 hour he Funera	Medical	(Check 2	Medical I	Physician: To the Examiner: On the ba Nurse Practitions	asis of examination	on and/or inve	stigation, in my	opinion,	death occurred a	it the time, date	and place	ce, and due to the	e cause(s) and manner stated.
		29b. Signature and	11/	069	m Aa w	(Sense ni	2143	8	29d D	ate signed (Mor	
94 d		30. Name and addr	EL LA	PENTA	ma, 4	45 D	EFEN	SE	HWY,	ANNA	POL	is mi	0, 21401
Stat Registra		31. Date filed (Mont	JAN 1	3 2012	Registrar's Signa	ature .	back						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 0258 Physician/ Dorothy W. Boland Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1ALBOT EASTON MEMORIAL HOSPITAL AT EASTON 8. Date of Birth (Month, Day, Dec. 5, g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 577-12-1314 Min. Months Hours 92 1919 Pennsylvania Dec. **Director** 1 ☐ M 2XX 28a-f shov 10d. Inside City Limits ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location Director Stevensville Oueen Anne's Maryland 1 Yes XXNo 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21666 119 Emory Circle U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify If Yes Give 3XXWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) U.S. Government Secretary event, the Be 18. Mother's Name (First, Middle, Maiden Surname) **Jennie Vogel** 17. Father's Name (First, Middle, Last) Benjamin J. Weissbrod ပ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Emory Circle Stevensville, Maryland 21666 19a. Informant's Name/Relationship (Type, Print)

Kathleen Sterling/daughter Department of Health a Important: If item 27 is any injury or other tract once. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 🔲 Burial 🏻 Cremation 3 🗀 Removal from State Baltimore, Maryland 1/17/2012 Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature 147 Duke of Gloucester St., Annapolis, MD 21401 Z23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** queritially list nonditions Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has it, page 2 s autopsy performed? 2 No this certificate 1 Tes Medical Certificate: To Other (Specify)

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After

State

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25. Was case referred to medical			26. Place of Death (Che	ck only one)
examiner? 1 Yes 2 No	lospital:	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 2 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature 29c. License number 29d. Date signed (Month,

and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washington St. Easton, MD 21601 Lame

(Check

only one

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eugene Beauvais, Jr. Month Day Year Arthur 2012 :50 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15510 Morning Mist Place Hughesville Charles Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 X M 2 □ F Months Yrs Director 53 19/1958 MA 022-48-6287 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Hughesville MD Charles Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20637 IISA 15510 Morning Mist Place death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Security Manager permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Messier Louise La Frenaye Arthur Eugene Beauvais, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15510 Morning Mist Place Hughesville, MD 20637 Gloriana Beauvais / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1

Burial 2

Cremation 3

Removal from State Brinsfield-Échols Crem 1/17/2012 Charlotte Hall, MD 4 Donation 5 Other (Specify) M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home, 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resultatory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cau e o, a ch line. Immediate Cause (Final Physician/ worder te to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exam burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Unknown Unknown P.0 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed cate has been s page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? e Hospital or Attending Physician: The I 124 hours after death. e Funeral Director: After this certificate h Was carse funeral director, referred to medical 26. Place of Death (Check only one) **Division of Vital** Be ner? Hospital: 2 🗆 No ၉ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 5 [of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d D scribe how injury occurred 5 Pending iniury Natural 1 Yes 2 🗆 No Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury — in home, farm, street, factory, office by ilding and (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifyi g hvs i edic min 29a. Certifier To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. • On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

• Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Cert , g Nur To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Pay, Year)

10[†]lone State

Registrar
DHMH 17 Rev 7/2009

30. Name and address 1 person wh

31. Date filed (Month, Day, Year)

C.

Boy,

MD

James

20650

Leonardtown, MD

41680, Miss Bessie Drive

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Arthur Bond, Sr. 2012 January 14 11:35 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22203 Newtowne Neck Road St. Mary's Leonardtown Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 1 (Mg/ntl), 9ay, 14-39 **Funeral** Months Days 578-58-5352 1 XM 2 🗆 F Hours 68 Director MD Usual Residence of Decedent 28a-f shov 10a State 10b. County the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No St. Mary's MD Leonardtown 10e. Street and Numbe 10f. Zip Code "natural", or items 23a o 10g. Citizen of What Country? Funeral with 22203 Newtowne Neck Road 20650 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify:Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me one. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be to of Health and Ments John H. Bond, Sr. Sarah R. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22203 Newtowne Neck Rd. Leonardtown, MD.20650 Dorothy Bond/ Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place! 4 ☐ Donation 5 ☐ Other (Specify) Charles Mem.Grdns 01/20/12 Leonardtown, MD . Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Home 38576BrettWay Mechanicsville,MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ho Physician/ disease or condition resulting in death) D GKI Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law the control of the contro that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform yes 2 No 1 Yes 2 No 8 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Yes Other: ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0014168 in death (Item 23a) (Type, Print)
26/103 Three Notch Rd suite101 mrcflesville, md 20659 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4) Rome

DHMH 17 Rev 7/2009

State

Registrar

KOKERT J. BAUMR, MO

JAN 1 9 2012

egistrar's Signatu

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 4	4 Donation	5 Other (S	Specify)		A11						/2012		arlot			
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DHMH 17 Rev 7/2009

Robert L. Balley		State of Maryland / Department of Health and Mental 1. For State Registrer Certificate of Death	Hygiene	Reg. No. 20	12 0290
Physicia Medical Exami		Robert Lorenzo Bailey	2. Date of D Month January		3. Time of Death 1352 hrs
Funeral		4a. Facility Name (if not institution, give street and number) University Hospital 5. Social Security Number 6. Sex 7. Ane (in vrs. last highbay) 16. University Number 17. Ane (in vrs. last highbay)	eath	4c. County o	more
Director		if Order 1 Year Ir Onder 24	Min.	Birth (MM/DD/YYYY) $1/1934$	Birthplace (State or Foreig Country) Maryland
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or items	Funeral Director	11. Marital Status 1 Never Married 2 X Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or I erto Rican, etc.)	United Si No- 14. Race - White,	American Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT user	of work done retired)	Specify:	White iness/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		12 Farmer	me (First, Middle	Farming	
MD 2121 nd 2 should be fulth and Mental mn 27 is marked	To Be	Robert Elmer Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	uise Noi	rris umber, City or Town	, State, Zip Code)
and and Healt tran		Violet Ann Bailey/Wife 37754 Louis Bailey Ro 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date Date	20c. Location - C	20609 City or Town, State
Baltimore, permit. Pages I an Importanti. If item injury or other tri		4 Donation 5 Other Specify: St. Joseph's Cemetery 01 21. Signature of Funeral Service Licensee 22. Name and Address of Facility B:	rinsfiel	d Funeral	Home, P.A.
Physician /Medical		Danielle Ward M01403 22955 Hollywood I 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a Subdural Hematoma			Approximate Interval Between Onset and
Examiner		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			Death
at a	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Ulsaste or hipur) that initiated events resulting in death) Last Due to (or as a consequence of):			
50, te be executed sysician and burial - transit		d UNPENDED AMENDED			
Records, P.O. Box 68760, The law requires that the death curtificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi-completed by Dhysician MALALI	ÈL	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	nancy	23d. Date of de Month	elivery Day Year
duires that the signed by all be detach	3	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death? Probably 4 Unknown
of Vital Records, ng Physician: The law require the this certificate has been signeral director, page 2 should by T.O.Re. Commission.) I				re autopsy findings available r to completion of cause of th? Yes 2 No
con of Vital I lending Physician: eath. or: After this certifithe funeral director, thion: To Be of	2	NT 84-	ing Home 5		Other:
C E . ~ 2 2		1 Natural 5 Pending Investigation 1 Yes 2 No	Subject fell	how injury occurred	
		Suicide 6 Could not be determined (Specify) Single Family Home 9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and mel	37754 Lewis	^{state)} Bailey Road, Aver	
To the Hos within 24 h To the Fur completely	2	me) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 9b. Signature and title of certifier 29c. License number	at the time, date	and place, and due	to the cause(s)
	3	O. Name and address of person who completed cause of death (Item 23a)		January 26, 2	
(c) PML State	3	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M 1. Date filed (Month, Day Year) 32. Fegistrar's Signature	ID 21223		
Registral DHMH 17 Rev 1/2001 OCME 2006	L	JAN 2 7 2012 Reserve B. Janes			

			For State	State of Ma	aryland / Depa	artment of F tificate of D		, 0	201	2 02002
			Registrar 1. Decedent's Name (First, Middle, La	est)	OGI	incate or L	Jean	2. Date of Death		3. Time of Death
	Physicia Medic			Р.	Burroughs			January	23, 2012	2:40 a M
	Examin	er	4a. Facility Name (if not institution, giv	,	rook	4b. City, Town, or Solom	Location of Death		4c. County of D	
3	Funeral		5. Social Security Number 6. 9		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director		216-12-4345 Usual Residence of Decedent	1 □ M 2 🛣 F	90 Yrs.	Months Days	Hours Min.	(Month, Day, 05/30/1		Country) Maryland
	and show lat	or	10a. State 10b. County		10c. City, Town or Loc	ation		1		10d. Inside City Limits
	Maryli 28a-f otifiec	irect	Maryland St. M	fary's	Mechani	csville				1 🗆 Yes 2 🛣 No
	th the 3a or t be n	al D	10e. Street and Number	_		10f. Zip Code		1	0g. Citizen of What	•
	ems 2 r mus	Funeral Director	28250 Old Villa 11. Marital Status	ge Road 12. Was Decedent E	ver in U.S. 13. V	206	spanic Origin? (Spe	ecify Yes or No-	471	S A
စ္တ	fter de , or it amine	by	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣	No It	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, W	/hite, etc.
Ö	ours a atural' cal Ex	Completed	3 ▼ Widowed 4 □ Divorced 15. Decedent's I	If Yes, Give Year or Dates.		Yes 2 No			Specify:	White
215	n 72 h an "na Medic	mple	(Specify only highest g.		(Give A	ent's Usual Occupa ind of work done d ONOT use retired)	ation luring most of work	ing	16b. Kind of Busine	ess/Industry
212	l withir ygiene her th t, the		12	College (1-4 of 5		ice Mana	ger		Insuranc	e Company
and	ntal Hice	To Be	17. Father's Name (First, Middle, Last)	D:11 .			18. Mother's Nam		-	
Maryland 21215-0036	nould to the second to the sec		William Archie 19a. Informant's Name/Relationship (on, Sr.	a Address (Street a	Helen	Mae	Wood City or Town, State,	Zin Code)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Dianne B. McWill	iams/Daugh						, MD 20659
Baltimore,	9 % = 5		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of atory or other place	e)	Date 2	20c. Location - City	or Town, State
	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Spec	**	St. Joseph			8/2012	Morganza	a, MD
Ra	Department Important any i		21. Signature of Funeral Service Licen	Fareline	$\begin{pmatrix} 22 \\ 4 \end{pmatrix}$	Name and Addres !attingle 590 Fense	ey-Gardin	er Funera	al Home, town, MD	P.A. 20650
T	-		23a. Part 1. Enter the disease, or comshock, or heart failure. List only	iplications that caused one cause on each line	the death. Do not ente	r the mode of dying	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between
ž	Physician/		Immediate Cause (Final disease or condition	a	ACV	D				Onset and Death
my de	Medical Examiner		resulting in death)		consequence of):	c od				YEMES
Ä		iner	Sequentially list conditions, in any, leading to immediate	b. —	consequence of,.	7 [1011 10
	cuted	xami	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
	cate be executed physician and s the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	consequence of):					
00/3	icate t	0		d						
X DX	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy 2 Fetal death 3	Ectonic pregnance	M		23d. Date of	delivery
POX	e death the att hed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at g ☐ Unknown		Other (specify)	,		Month	Day Year
Ö	hat the ed by detac	by Ph	Part II. Other significant conditions of	ontributing to death bu	rt not resulting in the ur	derlying cause give	en in Part I.	23e. Did toba	acco use contribute	e to the cause of death?
S,	luires f	ed b	DEUEN	TIX				1 🗆 Yes	s 2 1 1 3 1	Probably 4 Unknown
vital Records,	aw rec as bee	Completed				v ***		24a. Was an autopsy		autopsy findings available to completion of cause of
Ţ	: The I cate h							perform 1 Yes 2	ed? death	
Ita	sician certifi lirecto	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		Othe	r:			
0	ig Phy ter this neral c	te: To	27. Manner of Death	28a. Date of injury (Month, Day,	nt 2 ER/Outpatient / 28b. Time of injury	28c. Injury	at	me 5 ∟ Resider 28d. Describe how	ce 6 Other (Sp	pecify)
00	tendir leath. or: Aff the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	n		M 1□,	Yes 2 No			
DIVISION OF	l or At after c Direct d in by	Cert	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
_	ospital hours meral ly filled	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of r	ny knowledge, death o	ccurred at the time	, date and place, ar	nd due to the caus	e(s) and manner as	s stated.
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nur	iner: On the basis of ex se Practitioner : To the	amination and/or investi	gation, in my opinior death occurred at the	n, death occurred at le time, date and pla	the time, date and	place, and due to the	ne cause(s) and manner stated.
	BA		29b. Signature and title of certifier		MD	29c. License	and the second	29	d. Date signed (Mo	
	6		30. Name and address of person who	completed cause of de			56075		1-24	-12
	(0)		Raibinder S.	Gill, M.D.	24035		otch Rd.,	Hollywo	ood, MD 2	0636
	Stat Registra	e r	31. Date filed (Month, Day, Year) JAN 25	2012 32. Registrar	's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

e %			For State of Ma		artment of Health ar <i>tificate of Death</i>	•	giene Reg. No. 201	2 02903
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		<u> </u>	2. Date of Dea Month		3. Time of Death
	Medic	al	Emilio Baluyot 4a. Facility Name (if not institution, give street and number)	Balmaceda		Januar	y 22, 2012	3:30 a M
	Examin	ier	St. Mary's Hospital		4b. City, Town, or Location of E Leonardtow		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birtl	n g. Bir	rthplace (State or Foreign
	Director		545-90-0663 Usual Residence of Decedent	63 Yrs.		Min. (Month, Day 08/17/	1948 Ph	ilippines
1	yland f shov	tor	10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	r 28a- notifi	Director	Maryland St. Mary's 10e. Street and Number	Califor	rnia 10f. Zip Code		40 000 6145 40	1 Tes 2 No
	with the	Funeral	23283 White Elm Court		20619		10g. Citizen of What Co	ountry?
	ified within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Fun	11. Marital Status 12. Was Decedent E Armed Forces?		Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - Ame	
36	al", or	d by	1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ I If Yes, Give Year or Dates.	No	☐ Yes 2 No Specify:	,,	Black, White Specify:	lipino
21215-0036	hours naturi dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation		16b. Kind of Business	-
121	within 72 giene. ier than "r the Med	lmo;	Elementary/Seconday (0-12) College (1-4 or 5-	+) life. DC	rind of work done during most of O NOT use retired)		II (1 N -	
d 2	filed wi al Hygie d other event, tl	Be	17. Father's Name (First, Middle, Last)	Cnie	ef Master of Ar	MS Name (First, Middle, i	U.S. Na	vy
ylan	should be fil and Mental is marked aumatic ev	욘	Teodoro Mariano Ba <u>lm</u> a	aceda	Cat	alina Ba	luyot	
Mar	in and 2 should be fi of Health and Menta fitem 27 is marked rother traumatic ev		19a. Informant's Name/Relationship (Type, Print)	ı	g Address (Street and Number o			, ,
ē,	lealt		Estella V. Balmaceda/Wife 20a. Method of Disposition	2328 20b. Place of Dispos	33 White Elm Ct	., Califor	nia, MD 20 20c. Location - City or	
m 0	Page nent or ant: If iry or		1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) n National 02		Arlington,	
Baltimore, Maryland	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signeture of Funeral Service License		Name and Address of Facility attingley-Gardi 1590 Fenwick St			
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente				Approximate Interval Between
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Cardiac	arythmee			Onset and Death
مبسيا	Examiner		Due to (or as a	consequence of):	rua			menutes.
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):				menutes
	cuted and transit	Examiner	Cause (Disease or iinjury that initiated events c.	Carcino	me of the.	liver		years
0	icate be executed physicial and sthe burial-transit	edical E	resulting in death) Last Due to (or as a	consequence of):	U			
3760	ificate ig phys as the	Medi	d					
89 x	v requires that the death certific been signed by the attending should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the past 12 months?	2 🗌 Fetal death 3 📃	Ectopic pregnancy		23d. Date of de	*
. Box	ne dea / the a ched fa	ysic	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5 ∟	Other (specify)		Month	Day Year
Division of Vital Records, P.O.	that the	by Pi	Part II. Other significant conditions contributing to death but	it not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
rds,	een sig	ted				1 🗆 Y	′es 2 □ No 3 □ F	Probably 4 🗍 Unknown
900	law re has b	Completed	•			24a. Was a autop	sy prior to	utopsy findings available completion of cause of
E E	an: The tificate tor, pag		25. Was case referred to paedical	-	26. Place of Death (1 \Yes		s 2 No
Ĭţ;	hysicia his cer I direct	잍		nt 2 ER/Outpatien	_ Other:		ence 6 Other (Spec	cify)
n of	ding P h, After t funera	ate:	27. Mann f Death 1 Natural 5 ☐ Pending 28a. Date of injur (Month, Day,		28c. Injury at work? M 1 ☐ Yes 2 ☐ No	1	ow injury occurred	
Sio	Attender deat	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injur	ry - At home, farm, stre			treet and Number or Ru	ıral Route Number,
Ω	ital or irs afte al Dire		bullaing, etc.			City or Town		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of responsible to the basis of examiner. On the basis of examiner. To the basis of examiner.	amination and/or investi	igation, in my opinion, death occu	rred at the time, date ar	nd place, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	
	BA		30. Name and address of person who completed cause of de	oth /Itom 00=\ /Time D	D 2982		0 72	2,2012
	4(6)		JAMES ISSAM DAMALE	uJ(PO		WARDTOWN	V, MB 206	52
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registry JAN 2 5 2012		have s			
					JE 64/79			

State Registrar (Check

only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTENDING

MUSA MOMOHMD 12150 ANNAPOUS ROADHZUS, GLENNDAGE MD ZO769

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D52900

29d. Date signed (Month, Day, Year)

01:18:2012

29c. License number

31. Date filed (Month, Day, Year, 32. Registrar Signature

PHYSICIAN

12-00523

ary Anthony Bo	oddi	1- For State	of Maryland	•	artment of		and Me	ntal Hy	_	los No. 2	201	2 0290
Physicia		Registrar 1. Decedent's Name (First, Middle,Las							2. Date of Dea		Year	3. Time of Death
edical Exami	ner	GARY ANTHONY 4a. Facility Name (if not institution, giv			17	lb. City, Town	or Location	n of Death	Month January 1		nty of Deat	1930 hrs
		7206 Warwick Drive	e street and number,	'		Temple I		TOI Death			e George	
Funeral		5. Social Security Number 6. Se	ex 7. Ag	e (In yrs. I	ast birthday)	If Under 1		der 24Hrs.	8. Date of B	rth(MM/DD/Y	YYY) 9. Bir	rthplace (State or gn D.C.
Director		577 72 5626 1	2 F	56	Yrs.	Months [Days Hou	ırs Min.	JAN 7	7 1956	Co	D.C.
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on	-					10d. Inside City Limits
	Ļ	MD PG		TE	MPLE H	ILLS						1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		l		10f. Zip Cod	е	<u> </u>		10g. Citizen of	f What Cou	intry?
death with the Maryland or items 23a nr 28a-f sho must be notified at once.		7206 WARWICK	DRIVE			2	0784			U	JSA	
ath with the items 23a ust be not	uneral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Armed Forces?	2		s Decedent of es, specify Cu			ecify Yes or N Rican, etc.)		Race - Amer Vhite, etc.	rican Indian, Black,
	ш,		1 Yes 2 If Yes, Give Yeer	X No	1	Yes 2X	No specif	fy:		Speci	ify: BLA	CK
ours a	ed by	15. Decedent's Education (Specify or	Lor Dates: nly highest grade con	npleted)	16a. Decedent	s Usual Occupst of working				16b. Kind o		
36 in 72 h	plete	Elementary/Secondary (0-12)	College (1-4 or	5+)		NSPOR			,,,	FEDER.	AL G	OVERNMENT
d with	Completed	17. Father's Name (First, Middle, Last))		21(7)				First, Middle,	Maiden Surna	ame)	
21215-0036 build be filed within 7 Mental Hygiene. marked nither than it event, the Medica	Be (GEORGE BODDI	E SR.				AL	ICE F	ROBINS	ON		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. The marked nither than "natural", or items 23a nr 28a-f she natic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (T GEORGE BODDIE		munn		•				mber, City or		
E g th 2 ■		20a. Method of Disposition	•	20b.	Place of Disposi			I	Date	HILLS 20c. Locati		ZU / O 4 Town, State
Baltimore, permit. Pages 1 ar Department of Hee (important: If ite injury nr nether tr		1 Burial 2 Tremation 3		1 1.	TVERDAT	erplace) LE PAI	RK	1/	21/12	RIV	ERDA:	LE MD
Baltimo permit. Page Department o Important: injury nr ntt		4 Donation 5 Other Specify. 21. Signature of Funeral Service Licen				ame and Add		lity			-	20010
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Physician Microsoft		23a. Part . Enter the disease, or comp failure. List only one cause on ea	ach line.					cardiac or	respiratory ar	rest, shock, or	· heart	Approximate Interval Between Onset and Death
Examiner			Codeine ar Due to (or as a cons			ntoxic	ation					Death
7		Sequentially list conditions, b.										
	nlne	cause. Enter Underlying Cause	Due to (or as a cons	equence o	rf):							
ed isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	rf):				-			1
oe executed ician and irial - transit	dical	UNPENDED d.	AMENDED 23	a,27,	28a-f,p	er me,	g924 2	2-7-12	2 sm			
	Med	IF FEMALE:	23c. If yes, outcor	ne of preg	nancy					23d. Date	e of deliver	у
Box 68760, death certificate be ne attending physic of for use as the buri	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	time of de		al death	3 Ector	oic pregnar	су	Mont	h I	Day Year
Box 68760 re death certificate to the attending physical red for use as the bu	Physician/Me	1 Yes 2 No 9 Unknown	, L.J.		5 [_] Oth	ner (Specify)						
s, P.O. ires that the signed by t	by PI	Part II. Other significant conditions	contributing to deat	h but not re	esulting in the u	nderlying caus	se given in l	Part I.				the cause of death?
S, F quires i									24a. Was			bably 4 Unknown utopsy findings available
COFC law rehas be	Completed								auto perfo	psy orm <u>ed</u> ?		completion of cause of
Re if The ifficate if, page		25. Was case referred to medical				26 PI	ace of Deat	h (Check o		2 No	1 🗸 Y	es 2 No
Division of Vital Records, sa Arcading Physician: The law requires after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	o Be		lospital: 1 Inpatie	ent 2	ER/Outpatient		Other ₄	-	Home 5	Residence	6 🗹 Othe	r; Scene
ing Ph	_	27. Manner of Death	28a, Date of Inju (Month, Day,Y	ıry 'aar)	28b. Time of Ir	njury 28c.	Injury at Wo			how injury oc		1
Sion Attend death. sctor:	catlo	1 Natural 5 Pending 2 Accident Investigati	on fd 1-18		£d 07:14		Yes 2		alcoho.	1		codeine and
Divi	Certification:	3 Suicide 6 Could not determine	be		ome, farm, stree				or Town,	State) 7206 Hills.	Warw	ural Route Number, City
Hospi 24 hou Funer tely fil		29a Certifier	lan: To the best of m						_			ted.
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this co	Medical	one) 2 Medical Examine	r:On the basis of exa and manner stated.	mination a	ind/or investigati				the time, date			
	Σ	29b. Signature and title of certifier	~	1			ense numbe C.M.E.	er			signed (Mo	onth, Day, Year)
		30. Name and address of person who	completed cause of	eath (Ital	(23a)		V.141. L.			January	10, 201	
し			Assistant Medic	/		N. Baltimo	re Street	t, Baltimo	ore, MD 21	223		
St Regist	ate	31. Date filed (Month, Day Year) JAN 2 7 2012	32. Registra	s Signat	add							
Kegisi	116H	THE POIL P	ANTHO D	19						سا ۱۰۰ لیان		

DHMH 17 Rev 1/2001 OCME 2006

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			1 - State Of Mary Registrar		tificate of L			Reg. No. 2	112	02906
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month 01	th Day 15	Year	3. Time of Death
.,	/Medic	al	Betsy Ann Boland 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dooth	01		2012 y of Death	3:55A M
2.0	Examin	er	Holly Hill Nursing and Rehab		Towson	Location of Death		ł.	imore	
	Funeral		5. Social Security Number 6. Sex 7. Age (Ir	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Count	
	Director		Usual Residence of Decedent	62 Yrs.			12 24	1949	Holli	daysburg, P
	yland		10a. State 10b. County 10	c. City, Town or Loca	ation				10	d. Inside City Limits
	e Mai Ba-f s	Director	MD Baltimore T	owson						1 □Yes 2XXNo
	with th	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Count	ry?
	ns 23	Funeral	531 Stevenson Lane 11. Marital Status 12. Was Decedent Ever	in US 13 W	21286	spanic Origin? (Spe	ecify Yes or No-	US 14 Rs	ce - America	ın Indian
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the fladdel Evanriner i ust be notified at	by	Armed Forces? 1 XNever Married 2 Married 1 Yes 2 Xno If Yes 2 ive Year or Dates:	lf.	Yes, specify Cubai	spanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Speci	ıck, White, et	
2-0	72 ho 'natur	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupa	ation luring most of worki)	ng	16b. Kind of E	Business/Indi	ustry
121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	sales) -		cosmo	etic c	0.
	filed Il Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	Dailes		18. Mother's Name	(First, Middle,			
/lan	should be nd Mental marked o	To B	Norman A. Boland			Mary R.	Malliga	n		
Jar)	S S S		19a. Informant's Name/Relationship (Type. Print)	,	•	and Number or Rura			'	Code)
e, ≥	of Health item 27		Barbara J. Miller/sister 20a. Method of Disposition		ckens Squ		onium,		093	Chaha
Baltimore, Maryland	of High		4 Donation 5 Other (Specify)	20b. Place of Disposicemetery, cremate. Andrew	Cemeter	y 1/20/	2012	•	oro,	PA 17268
Bal	permit. Pag Department Important; any Injury c	n. j	21. Signature of Fund al Service Licensee		Name and Addres	s of Facility G			Funer 17268	al Home, I
	Physician be executed 'Medical Examiner as the burial-transit as the burial-transit	ledical Examiner	shock or heart failure. List only one cauke on each lin. Immediate Cause (Final disease or condition resulting in death) a	Musike III	leakness			40.		Interval Between Onset and Death
. Box	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year
rds, P.	e law requires that the de has been signed by the le 2 should be detached	5	Part II. Other significant conditions contributing to death but no		derlying cause give	n in Part I.	23e. Did to	1/		e cause of death?
ပ္က	: The law re cate has be page 2 sho	Completed					24a. Was a autop: perfor 1 🗆 Yes	sy med?_	Were autop prior to comdeath?	sy findings available opletion of cause of
VItal	ysician is certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3 □ DOA Othe	26. Place of Death			her (Specify	1
10 L	ng Ph fter thi	Ľ.	27. Manner of Death 12. Natural 5 Pending (Month, Day, Ye.		28c. Injury Work		28d. Describe h			,
SIO	tendii leath. tor: A the fu	catic	2 Accident investigation		M 1 □ Y	res 2□No				
DIVISION	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (S	At home, farm, stree Specify)	et, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the o	cause(s) and r	nanner as st	ated. the cause(s)
	To the within Го the	Mec	29b. Signature and little of certifier		29c. License	number	2	29d. Date sign	ed (Month, D	Pay, Year)
	,		* (Refeest Chalus MI)		10-0	04425		0/-2	27-2	012
7	Pan		30. Name and address of person who complete cause of death Robert E. Roby, MD 827 Lin	(Item 23a) (Type, Pi den Ave.	rint\		21201			
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature						

State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND #5 per INF, 1/27/12; BMW, MCCO Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Physician/ dward JAN. 6:40 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES GENESIS HEALTH CARE WALDORF If Under 1 Year 8. Date of Birth (Month, Day, Year, JUNE 2, 1 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 5.579-52-7899 1 X M 2 □ F Months Days Hours MARYLAND Yrs. **Director** JUNE Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Ves 2 No MD. PRINCE GEORGES UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a (amportant: If item 27 is marked other than "hatural", or items 23a (amp injury or other traumatic event, the Medical Examiner must be once. 10505 WYLD DR. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces

1 Y Yes 2

If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married ^{2 □ No} 1959-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced BLACK 1961 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) INSPECTOR OSHA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ THOMAS S. COLE THELMA В. HERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARA ANN COLE/WIFE 10505 WYLD DR., UPPER MARLBORO, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 A Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1-30-2012 RIVERDALE, MD. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final cances lung vysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Esquentially list sunditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Anxieli Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural
2 Accident
3 Suicide
4 Homicide work? injury 5 Pendina 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/18/2012 71199 Name and address of person who completed cause of death Aviation Blud, Ste B, Glen Busine, MO, 21061 Dr. Joslin 31. Date filed (Month, Day, State Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5per FH, 1/27/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HELEN FRANCES CESSNA 8,2012° 7:15 РМ January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Riderwood Silver Spring Prince Georges 21451243372 214-12-3371 If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ar. 13,1919 1 □ M 2 🛣 F Months Days Hours 92 Maryland **Director** Mar. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State rector 1 Yes 2 X No Silver Spring Maryland Prince Georges Ö 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20904 Funeral United States 3160 Gracefield Road #2114 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Elizabeth Boci Walter Edward McKenzie 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9535 Ashlyn Circle Owings Mills, MD 21117 Carol Frances Dombrowski 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 23, Jan. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2012 Silver Spring, MD 21. Signature of Suneral Service Lice 22. Name and Address of Facility DeVol Funeral Home oby 2 10 East Deer Park Dr. Gaithersburg, MD 20877 23a, Par 1, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Week shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Cerebral Vascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 1 requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No ò Month Day 5 Other (specify) Pregnant at time of death g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Congestive Heart Failure 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has page 2 certificate 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Hospital 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 V Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending X Natural Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical. pleted filled in by the S

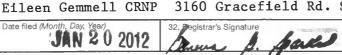
> State Registrar

29a. Certifier

(Check only one 29b. Signature and title of certi

onth, Day, Year) 31. Date filed (Month, Day, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year) 12

29c. License number

3160 Gracefield Rd. Silver Spring, MD 20904

		Plea	ase Type or Pri State of M					_		_	э.
	-	For State Registrar	Otate of W	ai yiai ia		tificate of L		Wichtai Fis	Reg. N	001	2 02909
Physicia: Medic	n/	1. Decedent's Name (First, Middle VERA	, Last)	C	EAR	2F055		2. Date of De Month	eath	ay Year	3. Time of Death
Examine		4a. Facility Name (if not institution 336 Red Magno				4b. City, Town, or Mille	r Location of Dear rsville	th	4	c. County of De Anne A	rundel
Funeral Director		5. Social Security Number 218–18–5300 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last 87	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)		Birthplace (State or Foreign Country) ryland
Aaryland 8a-f show tified at	Funeral Director	10a. State 10b. County	Arundel	10c. City, To		ville					10d. Inside City Limits 1 ☐ Yes 2 X] No
th the N 3a or 2 be no	al Di	10e. Street and Number				10f. Zip Code	•		_	Citizen of What	Country?
ath wit	nue	336 Red Magno	12. Was Decedent B	Ever in U.S.	13. V	2110		pecify Yes or No	<u> </u>	USA	nerican Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?		1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2X No		to Rican, etc.)		Black, Wh	
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12 should alth and Me 27 is mar r traumati		19a. Informant's Name/Relations Sharon Lindst	1 1 27			g Address (Street a					Zip Code) MD 21108
Page 1 and nent of Hee int: If item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (8)	3 ☐ Removal from State	20b. Plac Glen	e of Dispos etery crem Haven	sition (Name of eatory or other place Memoria Park	Janu	Date 20, 20, 2012	1	Location - City en Burn	
permit. Departr Imports any inju		21. Signature of Funeral Service	dur		22 E 4	Name and Address Arranco 95 Ritch	ss of Facility & Sons, ie Hwy,		vern vern	a Park a Park,	FuneralHome MD 21146
Physician/ Medical		23a. Par . Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		mer	Do not ente	r the mode of dyin	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
Examiner	-i	Sequentially list conditions,	b. ———								
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or Attending Physician: The law requires that the decth certificate be after death. Director: After this certificate has been signed by the attending physicia in by the funeral director, page 2 should be detached for use as the but	\	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal de	eath 3 L	Ectopic pregnand Other (specify)	су			23d. Date of o	delivery Day Year
v requires that the des been signed by the should be detached	by	Part II. Other significant condition	ons contributing to death b	out not resulti	ing in the u	nderlying cause giv	ven in Part I.				to the cause of death? Probably 4 Unknown
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l or Attend after death Director: /	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide detern	not be 290 Place of Init		e, farm, stre	M 1 — eet, factory, office	Yes 2 No	28f. Location City or To			Rural Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 Medical I	Physician: To the best of Examiner: On the basis of e Nurse Practitioner: To the	examination ar	nd/or invest	igation, in my opinio	on, death occurred	d at the time, date	and place	ce, and due to th	e cause(s) and manner state
To the within comp	_	29b. Signature and title of certifie	1) Lan	Da un	7	29c. Licens	e number NY38		2001.	Date signed (Mo	nth, Day, Year) 16 2012
H5		30 Name and address of person.	who completed cause of d		Sa) (Type 5	rint) EYE NSE	- High	WAy A	Nort	APOLIS 1	MDZIYOI
Stat Registra		31. Date filed (Month, Day, Year)	2012 32/Registra	ar's Signature	ha	aled .					

State Registrar Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	e Type or Prin					-	_	·.
	-	For State Registrar		iryland /		artment of He tificate of De		, ,	ene g. No. 201	2 02910
Physicia Medic		1. Decedent's Name (First, Middle, L Nathaniel Cro	wner					2. Date of Death Month anuary	13 201	3. Time of Death 2 11:45A M
Examin	er	4a. Facility Name (if not institution, g 5644 Deale Ch	· ·	d .		4b. City, Town, or L Church			4c. County of Dea	ath rundel
Funeral Director		5. Social Security Number 217-30-3891	. Sex 1 X M 2 \square F	(In yrs. last &	birthday) 5 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth A(Month, Day)	^{9.8} 936 M ⁹	rthplace (State or Foreign Tyland
aryland a-f show ffied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne		10c. City, To	own or Loc rcht					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 5644 Deale Ch	urchton Ro	l .		10f. Zip Code 2073	33	10	g. Citizen of What C	country?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 N If Yes, Give 1 C Year or Dates.	Jo	li li	Vas Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto F		14. Race - Am Black, Whi Specify:	
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ending Preath.	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no		Year) 28t	b. Time of injury	work?	at 2	8d. Describe how	injury occurred	
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	al Certi	4 Homicide determine	ed 28e. Place of Injury building, etc.	(Specify).				City or Town,		
the Hosp thin 24 ho the Fune smpleted fi	Medical	(Check 2 L Medical Exa	hysician: To the best of maminer: On the basis of exa urse Practioner: To the b	amination and	d/or invest	igation, in my opinion,	death occurred at ime, date and place	the time, date and e, and due to the c	place, and due to the ause(s) and manner a	e cause(s) and manner stated.
5 3 5 8		30. Name and address of person wh	. Brys	t c	ROU,	P RIZ	4971		d. Date signed (Mon	12 January 18
Hatl	0	Nancy S. Bryan	1 + CANA 32. Registrar	13 4	o Cur	ensville	Road	West	River	MD 20778
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 16, 2012 2:11P Carolyn E. Cartney Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 3607 Melfa Lane Bowie Social Security Number If Under 1 Year_ If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Hours 170-24-8222 Director 1 🗆 M 2 🔀 F 81 Yrs Nov. 14, 1930 Pennsylvania Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location. 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 3607 Melfa Lane 20715 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Giant Foods ith and Mental Hygien 27 is marked other tl r traumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be Health and Menta Francis E. Baldwin Margurite E. Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Janice Loos/daughter 8960 LightningLane, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Lakemont Mem. Grdns 1-21-2012 Davidsonville, MD Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death KENAI Cell CarcinomA Phylician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforn death? certificate 1 ☐ Yes 2 ☐ No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 24 hours after death. Funeral Director: A 1 Yes Accident Investigation
6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State

within 24

31. Date filed (Month

MODILO ton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BSS Greenway CTE OF Greenbeth MD 20770 egistrar's Signatui

Registrar

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D53J43

29d. Date signed (Month. Day, Year)

1-17-12

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State	10b. County		10c. Cit	y, Town	or Location						100	d. Inside City Limits
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Jing Ph After th funeral		27. Manner of Death 1 X Natural	5 Pending	28a. Date of (Month,	injury Day, Year)	28b. Tir	ne of ury	28c. Injur work	y at	28d. Describe				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ 2:20 PM Charlotte Ann Coppage January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Lexington Park Chesapeake Shores 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 7. Age (In yrs. last birthday) Country) st <u>Virginia</u> (Month, Day, Year, uly 23, 1 M 2 0 F Months Hours Min. 70 West Director 220~72-3714 July. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director 1 Yes 2X No Great Mills St. Mary's <u>Maryland</u> 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral **IISA** 4502 Dogwood Lane 20634 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Housekeeper 12 event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Mae Woodard Ireland Leedy Coppage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4225 Meadowbrook Place Waldorf, MD Ruby Mae Breitenbach/ Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b, Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 01/21/2012 Jeffersonton, VA Hillcrest Memory Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, 41590 Fenwick Street Leonardtown, MD of Funeral Service Licens P.A. 2<u>0650</u> 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ tu disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any localing to in result cause. Enter Underlying Cause (Disease or linjury that initiated events signed by the attending physician and deed be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No Be 25 Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) 2) pml CRI

State Registrar JAN 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21, 2012 Year Margie Marie Combs January 4:50 p.m.^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Min. Hours Virginia 10 Month, Day 1939 215-38-5765 72 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director must be notified with the Man Maryland St. Mary's 1 Yes 2 x No Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20563 Ridge Road "natural", or items 23a Funeral 20653 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ♣ No Be Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 😾 Widowed 4 🗌 Divorced Specify: White Year or Dates and Mental Hygiene.
I is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) int. Page 1 and 2 shous.

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"her fraumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leonard Walker Freeman Venus Nora Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Combs- Daughter permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other t 20563 Ridge Road, Lexington Park, Maryland 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Holy Face Cemetery 01/26/2012 Great Mills, Maryland 21. Sign / a of Funeral Service Dicense Mily acce Kathleen A. Santivasci MOOS 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00872 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
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• Funeral Director, After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: Hospice Certificate: To 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 XOther (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpleted filled in by 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my color 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, MOUSS75

1) Rml State

Registrar JAN 2 4 201

DHMH 17 Rev 7/2009

30. Name and address of pe

31. Date filed (Month, Day, Year)

Schmidt,

Jennifer

32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

M.D.

40900 Merchants Lane, Leonardtown, MD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	esidence of D	Decedent 10b. County	,		1/	no City	Town or Lo	ention								
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.	g in death) La	ıst		Due to (o	r as a co	nseque	nce of):									
IF FEMA 23b. Wa: in ti 1 9	_		d. ,													
IF FEMA	LE: s decedent p	regnant	23c	If yes, outco	ome of p	regnan	су							00 I D-1	- 5 - 1 - 0	10
in the	he past 12 m	onths?		1 Live B	irth 2. □ antattim	Fetal	death 3	Ectopic Other (s	pregnanc	У			Ī	23d. Date Mon		ery Day Year
9 🗆	Unknown			9 LJ Unkno			_									
2	Other signific	ant condition	ons contri	outing to dea	ath but n	ot resul	ting in the u	ınderlying	cause giv	en in Part	l.					e cause of death?
-												1 🗆	Yes 2	□ No	3 🗌 Prob	pably 4 Hunknown
		-										24a. Was auto	psy	iq	rior to cor	osy findings available inpletion of cause of
												perfe 1 🗌 Yes	ormed? 2 📉 N	lo 1	eath?	2 🗆 No
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	Natural Accident	5 Pendir			, Day, Ye		injury	М	work		_ 1	zod. Describe i	now injui	ry occurred	1	
3 4	Suicide Homicide	6 Could determ	not be	28e. Place o			e, farm, str	eet, factor	ry, office		_	28f. Location (Street an	nd Number	or Rural	Route Number,
				bullulity	g, etc. <i>(</i> S/	Deciry)						City or Tov	vn, State	e)		
29a. Ce	neck 2 L	⊔ Medical E	Examiner:	On the basis	of exam	ination a	and/or inves	tigation, in	my opinio	n death n	courred at	d due to the ca	and place	and due	to the cal	sele) and mannor etated
(0)	iyone) 3 L	Certifying le of certifier	Nurse Pi	actioner: To	the best	of my k	nowledge, o	death occi	c. License	time, date	e and plac	e, and due to th	ne cause(s) and man	ner as sta	ated.
on.	nature and til				0		22.0				_		29d. Da	ite signed	(Month, L	Jay, Year)
29b. Sigi		lune	KOL	restel	נוסא	, 1	פח		1)62	7115	7	- 1	1	1/100	10-	10
onl 29b. Sigi	Joces								Joce	_		tchou	M.D	171	20	12
29b. Sigi		s of person	who comp	leted cause	of death	(Item 2	3a) (Type, F	rint)	Joce	lyne	Koua	tchou,	M.D	171	20	12

DHMH 17 Rev 7/2009

12-00673								
Trov Collison								

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

oy Collison		Registrat	ertificate o		a ivientai i	, ,	eg. No. 201	2 0291				
Physici ledical Exam		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month January 2	oth Day Year	3. Time of Death 1725 hrs				
		Troy Lee Collison 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		th	4c. County of Deat	1				
Funeral		Meritus Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday)	Hagerstown		rs 8 Date of Bi	Washington rth(MM/DD/YYYY) 9. Bii	tholace (State or				
Director		212-06-5116 ₁ X _{M 2} F 39	Yrs	Months Day			Eorgi					
any		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Locat	tion				10d. Inside City Limits				
Aaryland 28a-f show	ō	Maryland Washington Co. H		1 Yes 2 No								
th the Maryla 23a or 28a-f notified at o	Director	10e. Street and Number	0g. Citizen of What Cou	ntry?								
with th ns 23a	ral D	125 Randolph Avenue 21740 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - Am										
er death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.										
nurs afte ntural?; amines	至	3 Widowed 4 Divorced If Yes, 6ke Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	Yes 2 X No	ion (Give kind of		Specify: W	nite				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers in Department of Health and Mental Hygiers than "natural", or items 23a, or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	75007	ost of working life. Chanic	. DO NOT use re	tired)	Self Em	oloyed				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Edward E. Collison				e (First, Middle, 1 e Sweene	Maiden Surname)					
21; should b nd Men is mar	Tol	19a. Informant's Name/Relationship (Type, Print)			t and Number or	Rural Route Nun	nber, City or Town, State					
and 2 shortest and 2 shortest and 1 shortest and 1 shortest and 1 stem 27 is traumatic		20a. Method of Disposition 20b.	. Place of Dispos	sition (Name of cer	e Koad,	Hagerst	town, Maryla 120c. Location - City or					
Baltimore, permit. Pages 1 an Department of Hea Important: If iter		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or ott mithsbur	^{herplace)} 1g Cr emat	ory Ja	n. 28,20	12 Smithsb	ırg, MD				
Balti permit. Departn Imports		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Hor 1331 Eastern Blvd. N, Hagerstown, MD 21742										
Physician		23a. Part I. En/fer the disease, or complications that caused the death failure. List only one cause on each line.	h. Do not enter t	he mode of dying,	such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and				
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Fentany1 Into		<u> </u>				Death				
	L	Sequentially list conditions, b				· · · · · · · · · · · · · · · · · · ·						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated										
ruted nd ransit	l Exa	events resulting in death) Last Due to (or as a consequence of d.	of):									
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. 68760, certificate be executed nding physician and ise as the burial - transi	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth		tal death 3	Ectopic pregn	ancy	23d. Date of delivery Month	ay Year				
Box 6876 he death certificat the attending phy hed for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	leath 5 Ot	her (Specify)								
P.O. I as that the gned by the detacher	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause g	iven in Part I.		obacco use contribute to					
ords, P.O. In requires that the as been signed by the should be detached.						24a. Was a		opsy findings available				
of Vital Records, ag Physician: The law require Mher this certificate has been sinneral director, page 2 should be	Completed					autop perfor	med? death?	ompletion of cause of s 2 No				
tal R cian: T certific ector, p	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2			of Death (Check	only one)						
of Vi g Physi Rer this leral dir	욘	27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of Ir		Other Nursi		Residence 6 Other					
C = 1 - 2	ation	1 Natural 5 Pending Investigation Fd 1-24-12 fd 04:52 pm 1 Yes 2 No Subject took non-prescribed medication										
Division of popular or Attending Phones after death. ours after death. filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	nome, farm, stree :Reside	•	uilding, etc.	28f. Location (S or Town, Si Hagerst	Street and Number or Ruitate) 125 Rando	al Route Number, City				
Ho Fur	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) 2 Medical Examiner: On the basis of examination a	dge, death occun	red at the time, dat		due to the cause	e(s) and manner as state					
To the within To the comple	Med	29b. Signature and title of certifier		29c. License			29d. Date signed (Mor					
		and 2.		O.C.N	M.E.		January 25, 2012					
P		 Name and address of person who completed cause of death (Iten Ana Rubio MD. Assistant Medical Examiner 		more Street, E	Baltimore, M	D 21223						
St Regist		31. Date filed (Month, Day Year) 32. Registrar's Signat	ure	-								

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		riea	se type or P					-		gible.	
		For State	State of	Maryland / D	•			/lental Hy	giene	010	00010
	-	Registrar 1. Decedent's Name (First, Middle,	(act)		Certificat	e or De	eatn	T	Reg. No. 2	012	02918
Physicia	n/							2. Date of Dea	Day	Year	3. Time of Death
Medic Examin		Phyllis Faye D 4a. Facility Name (if not institution,		ar)	4b City	Town or Lo	ocation of Death	1) come	1	DOIL ty of Death	1420PM
LAGIIRII	CI	Meritus Medica		.,,		gerst		V		ingtor	1
Funeral				Age (In yrs. last birth	day) If Unde	r 1 Year I	f Under 24 Hrs.	8. Date of Bird	:h	9. Birthp	lace (State or Foreign
Director		526-58-9259	1 □ M 2 💢 F	68 Y	Months rs.	Days H	Hours Min.	(Month, Da		Virg	
how at	r	Usual Residence of Decedent 10a, State 10b. County		10c. City, Town	or Location			0000		1	0d. Inside City Limits
anylar ta-f s ified	ecto	Maryland Washi	ngton		ar Spri	no					1 ☐ Yes 2 X ☐ No
or 28	ä	10e. Street and Number			10f. Zip				10g. Citizen o	f What Coun	try?
with s 23a ust b	Funeral Director	13813 Broadford	ing Road			21722			USA		
death item	Fur	11. Marital Status	12. Was Decede	s?	13. Was Deced	lent of Hispa	anic Origin? (Spe Mexican, Puerto		14. Ra	ace - Americ	
after I", or xamiu	d by	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 If Yes, Give	X No	1 Yes			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Speci	ack, White, 6 fv: Whi	
atura cal E	Completed	15. Deceden	Year or Date:		Decedent's Usua						
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within giene ier th	ပ္ပိ	8	0		cker				Glas	s Mfg.	•
filed tal Hy defined of the contract of the co	To Be	17. Father's Name (First, Middle, La	ast)			18	8. Mother's Nam	e (First, Middle,	Maiden Surnai	me)	
uld be I Men narke natic	-	Leroy F. Piggot				T	amsy Lu	cille Cl	napman		
2 shorth and 17 is not traun		19a. Informant's Name/Relationshi					d Number or Run				ŕ
and Heali tem S		Roger A. Dorsey 20a. Method of Disposition	– Husband		813 Bro Disposition (Nan			ad, Clea	ar Spri 20c. Location		1. 21722
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S _t		ate cemetery	crematory or o	ther place)				-	
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Physician/		Immediate Cause (Final disease or condition	MASS	IVE CEA	BROVA.	Wias	n Acc	DENT (PROBAG	i ==)	Onset and Death
Medical Examiner		resulting in death)	Due to (or	as a consequence of):						
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The lar)om	MSCITE(rmed?	death?	npletion of cause of
ertifica ctor, p	Be C	25. Was case referred to medical		•		26. Place	e of Death (Chec		2 7 1101	1 100	2.3110
hysic this ce	입	1 ☐ Yes 2 🗷 No		patient 2 ER/Out		Other:	4 Nursing Ho	ome 5 Resid	dence 6 🗆 O	ther (Specify)	
Jing F	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	9		ury	8c. Injury at work?		28d, Describe h	ow injury occu	rred	
death ctor: / y the	tific	2 Accident Investig	ot be	Injury - At home, farr	M M		s 2 🗆 No	28f. Location (5	Stroot and Alum	har or Puml	Pouto Number
al or A after Direct		4 Homicide determin		etc. (Specify)	ii, stroot, ractory	, omcc		City or Tow		ber or nurar	noute Number,
ospita hours ineral ly fille	Medical	29a. Certifier 1 Certifying	Physician: To the bes	t of my knowledge, d	eath occurred a	t the time, d	late and place, a	nd due to the ca	ause(s) and ma	nner as state	ed.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Mec	only one) 3 L Certifying	Nurse Practitioner: To	of examination and/or the best of my know	edge, death occ	my opinion, ourred at the t	time, date and pl	t the time, date a ace, and due to t	nd place, and o he cause(s) and	lue to the cau I manner as s	use(s) and manner stated. Itated.
or or or		29b. Signature and title of certifier	1000	1/201	290	License nu	umber		29d. Date sign	ed (Month, L	Day, Year)
			Julan / M	0 131	2	246	561		JAN	23	, 2012
J-3		30. Name and address of person w	the completed cause of DMILL	i (90 M)		. Rom	HALL	MIDWN	MO a	2174	·O'
Stat		31. Date filed (Month Physical)		istrar's Signature	11 6.10 0		(41, 60)	A - 11 0 041 0	1.00	\sim LI	
Registra	ar	J.111 J. 1	- Com	wa B.	park						

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physicia Medic		1. Decedent's Name (First, Middle, Last)	State of Maryland, Cperff, 1/25/12, 5/12;BW,MCo Louise Marie 1 RNELL	Darnell		2 Data of Dooth		3. Time of Death 1135 A M			
Examin		4a. Facility Name (if not institution, give st	,	_	or Location of Deatl		4c. County of Deat				
Funeral		Manor Care Potoma	7. Age (In yrs. last bi	Potoma irthdav) If Under 1 Yea		8. Date of Birth	Montgom	thplace (State or Foreign			
Director		577-44-3504 1 L Usual Residence of Decedent	M 2	Yrs. Months Days		June 24	,1934 Was	thiplace (State or Foreign untry) Shington, DC			
8a-f shortified at	rector	10a. State 10b. County DC None	1 '	wn or Location shington, DO	2			10d. Inside City Limits 1 A Yes 2 No			
s 23a or 2 ust be no	Funeral Director	10e. Street and Number 4201 Butterworth	Place, NW	10f. Zip Code	20016	10	10g. Citizen of What Country?				
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2▼ No If Yes, Give Year or Dates.	13. Was Decedent of If Yes, specify Cul	ban, Mexican, Puert	14. Race - Ame Black, White Specify: W					
ene. than "natu he Medical	3 Widowed 4 Divorced Vear or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Yes 2 Lano Specify: Specify: Specify: Specify: Specify: Specify: Specify: Information Analyst U.S.										
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ID No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		ncy		23d. Date of del Month	livery Day Year			
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sertific ector,	Be	25. Was case referred to medical examiner?	spital:		Place of Death (Che	ck only one)					
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after death Director: A J in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	M 1 [Yes 2 No	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,			
24 hours Funeral leted filled	Medical	(Check 2 L. Medical Examine	ian: To the best of my knowledge r: On the basis of examination and/	or investigation, in my onit	ion death occurred:	at the time date and	place and due to the	cause(s) and manner stated			
withir.		29b. Signature and title of certifier Praky	Practioner: To the best of my know	29c. Licen	se number	29	d. Date signed (Month				
		30. Name and address of person who con	npletted cause of death (Item 23a)	(Type, Print)	11/15	11 202	7.11	n, m2 x 1844			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:00 PM Mary Milburn Dunaway 2012 01 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's Hospice House of St. Mary's Callaway Social Security Number If Under 8. Date of Birth g. Birthplace (State or Foreign If Under 24 Hrs . Age (In vrs. last birthday) Months Days (Month, Day, Year) 06/14/192 Min 1 M 2 T F Hours 89 <u>Massachusetts</u> 578-22-5637 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27205 Widow Lane 20659 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Henry Sadie Gibbons Holly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 27205 Widow Lane Mechanicsville, MD Martha Jean Barnett/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/31/2012 Arlington, VA Arlington National ^{22. Name and Address of Facility} Mattingley-Gardiner Funeral Home, 1 41590 Fenwick Street Leonardtown, MD Signature of Funeral Service Licer P.A. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed

After thi

n 24 hours after death.

e Funeral Director. A sleted filled in by the fu

within 2 To the I

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

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28a-f show

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27 is marked other than traumatic event, the Me

permit, Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve

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Baltimore, Maryland 21215-0036

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Funeral

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Examine and -tran attending physi signed by t cate has page 2 s

Physician/Medical þ Completed Be 유 Certificate:

Medical

FFEMALE: 13b. Was decedent pregnant in the past 12 months? 1 Yes 2 Tho	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌 Ectopic			23d. Date of delivery Month Day Year			
Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
				1 ☐ Yes 2	2 No 3 Probably 4 Unknown			
				24a. Was an autopsy performed?				
5. Was case referred to medical			26. Place of Death (Chec	ck only one)	Hos ice			
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ [OCA Other: 4 \(\sum \) Nursing H	Iome 5 Residence	6 K Other (Specify) House			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigs	ition	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred			
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Place of Injury - At h	1 28a Place of Injury - At home farm street factory office 1 29f Location (Street						

29a. Certifie (Check only one)

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

H0055751

29d. Date signed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Mary Schmidt, MD 40900 Merchants Lane Suite 205, Leonardtown, MD Jennifer

20650

State Registrar

7) ence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O 1 Physician/ HOULE DEMKO 20 281Z MARTE VIVIAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST, MARY'S HOSPETAL ST. MARRY'S EONAMOTOWA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🏻 F Days Hours Min (Month, Day, Year) 04/28/1955 019-46-0177 Yrs 56 Director Massachusetts Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Saint Inigoes Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20684 USA 48593 Seaside View Road Lot 25 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Dietician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ Florence Bertha Shaw Dennis Joseph Houle, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 558 Johnson Mill Road Hamilton, GA William Houle/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory of other place)
Mattingley-Gardiner
Funeral Home, P.A. Crematory 01/21/2012 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, MD. 20650 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATTL Pttyrician ENCEPHALOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hours FULMENANT HIEPATTE Sequentially list conditions, Examine Due to for as a consequence of. it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical HOULE VIV CUV IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be ALCUMOL ABOUSE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available POLYSUBSTANCE ARUSE 24a. Was an autopsy performed has prior to completion of cause of death? 1 Yes 2 No certificate Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending injury work?
1 Yes 2 No Investigation □ Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 05 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eme

31. Date filed (Month, Day, Year) State **JAN 23** Registrar

BRUCE ROBERT GERSON 25500 POINT LOUKOUT ROAD LEGINARIOTOWN MD 32. Redistrar's Signature

Bella

20650

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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	-	1 - State Registrar	iviaryiand		rtment of l		and iv		giene Reg. No.	2.0	10	02023		
Physicia	n/	Decedent's Name (First, Middle, Last)						2. Date of De	ath		Your	3. Time of Death		
Medic	al	NANC		DEL	L'ANGELC			Januar	y I	.7 2	Y012	2:05 A M		
Examin	er	4a. Facility Name (if not institution, give street and number			4b. City, Town, o		of Death			c. County of Death Frederick				
Funeral			LCaL . Age (In yrs. last	birthday)	Frede	If Under		8. Date of Birt	th	Fred	9. Birthplace (State or Foreign			
Director		111-24-2223 1 □ M 2 🖾 F	81	Yrs.	Months Days	Hours	Min.	$\mathrm{Jull}^{(Month,\ Da)}_{1}$, Year) , 19	30 N	New York			
show	o	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation						10	0d. Inside City Limits		
28a-f s	rect	Maryland Frederick	Fre	deric	k							¥XYes 2 □ No		
3a or 2 t be no	Funeral Director	10e. Street and Number 7081 Catalpa Road			10f. Zip Code	1703				izen of W	hat Coun	try?		
ems 2 r mus	nuel	11. Marital Status 12. Was Decede	ent Ever in U.S.	13. W	as Decedent of H		nin? (Spe	cify Yes or No-			- America	an Indian,		
or ite	Armed Forces? 1 Never Married 2XXMarried Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black									, White, e				
tural" al Exa		3 Widowed 4 Divorced If Yes, Give Year or Date	es.		Yes 2X No					Specify:	WII	Tre		
n "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give ki	ent's Usual Occup ind of work done	during most	t of workin	ng	16b. Ki	nd of Bus	siness/Inc	dustry		
giene. er tha , the l														
dental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Joseph Cosentino						(First, Middle, a Arena		Surname)				
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Raymond Dell Angelo Hu	ısband		g Address (Street Catalpa							1703		
ent of He nt: if iten y or oth		20a. Method of Disposition 1x Burial 2 □ Cremation 3 □ Removal from S 4 □ Qonation 5 □ Other (Specify)	State cen	netery, cremi	ition (Name of atory or other pla chre Cem	ce)	1-25	-2012			-	wn, State , New York		
porta porta y inju		21. Signature of Funeral Service Licensee	1)1		Name and Addre		y Sta	uffer F	uner	al H	lome			
2 = 8 9		Maront amile C	elle	e 16:	21 Oposs	umtow	n Pi	ke, Fre	deri			land 2170		
ysician/ Medical		23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) a	r as a consequer		•		cardiac o		rest,			Approximate Interval Between Onset and Death		
xaminer		Sequentially list conditions, b. ————	(ovon		tery	di	icase				years.		
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		irth 2 🗌 Fetal o ant at time of dea	death 3 🗌	Ectopic pregnan Other (specify)	су		***************************************		23d. Date Mon	e of delive th	ery Day Year		
ned by e deta	by Pt	Part II. Other significant conditions contributing to dea	ath but not result	ing in the un	derlying cause g	ven in Part I	l.	23e. Did to	obacco u	se contril	bute to th	e cause of death?		
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e 2 shi	Completed	Hypertension						24a. Was auto	osy	pı	rior to con	osy findings available inpletion of cause of		
icate r, pag		Renal failure						1 \(\text{Yes}	rmed? 2 X No		eath?	2 🗆 No		
certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		2/0-1	Oth	lace of Deat								
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n 24 hour ne Funera pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis only one) 3 Certifying Nurse Practitioner: T	of examination a	.nd/or investig	gation, in my opini	on, death oc	curred at	the time, date a	ind place,	and due	to the cau	se(s) and manner stated		
To the Community		29b. Signature and title of certifier	- M 7		29c. Licens				29d. Date	e signed	(Month, E	Jay, Year)		
						1989			Y1	7/8	2012			
7		30. Name and address of person who completed cause WARZ. A. GUSSAIN	MO	25.7	7 DRIVE	P	RED	FRICK	H) D	LIM	02		
Stat Registra	_	31. Date filed (Month, Day, Year) 32. Rec	istrar's Signatur	A. A	arkel				-					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Robert Charles Dishong January 9 6:30 P Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Northhampton Manor Nursing Home Frederick Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min Hours 220-16-6185 **Director** 1 X M 2 □ F 87 April 3, 1924 Pennsylvania Usual Residence of Deceden show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21788 10 Orchard Drive items 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. WW I 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married 9 by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced WW II White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) MD State Police State Trooper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ other traumatic Walker Dishong Laura Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10 Orchard Drive, Thurmont, MD Mathilda Dishong/ Wife 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 1/13/12 Smithsburg, Maryland 21. Signature of Funeral Arvice Lice see 22. Name and Address of FacilityRobert E. Dailey & Son F.H., P.A. 23a. Part 1. Enter the disease, or North Market Street, Frederick, MD 21701 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a con requence of Hospital or Attending Physician: The law requires that the death certificate be executed and I-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Physician/Medical P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Pregnant at time of death Dav Year the 1 ☐ Yes 2 L g ☐ Unknown Unknown signed by 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 10 NO 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed Yes certificate 2 🗆 No 1 🗌 Yes Division of Vital funeral director, as case referred to Be 26. Place of Death (C rck only one) examiner? Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient Sursing Home 5 Residence 6 Other (Specify) this Death 28a. Date of injury 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: Funeral Director; After stely filled in by the funer (Month, Day, Year) 5 Pending Natural death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 3 Certifying Nurse Practitioner-To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar
DHMH 17 Rev 06-2011

State

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29b. Signature and title

Registrar's Signature

29d. Date signed (Month, Dav. Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Examin	er	4a. Facility Name (if	not institution, giv	e street and number)	e 1.	_	4b. City,	Town, or	Location of Death		40	. County	of Death	11	
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death items	Funeral	11. Marital Status	icha (130	12. Was Decedent I	Ever in U.S.	13.	Vas Decec	ent of His	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	П		ce - American Indian,		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	Be	17. Father's Name (11 uC	K DII	ver	18. Mother's Nam	e (First, Middle,			ortat	10n	_
Ild be i Menta narked	욘	Thomas	William	Dement					_Lena	May 5	Thor	nton			
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1 and of Heal item other		Vicki Ri 20a. Method of Disp	osition	<u>Daughter</u>	20b. Pla	ace of Dispo	sition (Nar	ne of	Barstow,	Date	0610 20c. L		City or To	wn, State	_
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permit Depar Impor any in		21. Signature of Fu	neral Service Licer		MOO71				s of Facility Rat						
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	(Check 2	🖳 Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination a	and/or inves	tigation, in	my opinio	n, death occurred a	the time, date a	and place	e, and due	e to the car	use(s) and manner sta	ted.
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DHMH 17 Rev 7/2009

Daniel Richard Die	effenbach 1- For State Registrar	State of Maryla		irtment of tificate of		d Mental I		2 0	12 0292
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, 1	4a. Facility Name (if not ins Calvert Memorial	. •	umber)	4	b. City, Town, or Prince Fred	Location of Dea derick		4c. County of Calvert	Death
Funeral Director	5. Social Security Number 213–76–7738	6. Sex 1 X M 2 F	7. Age (In yrs. Ia 52	ast birthday) Yrs.	If Under 1 Year Months Day	ar If Under 24H s Hours M			9. Birthplace (State or Foreign Country)Japan
in the Maryland 23a or 28a-f show any notified at once,	Usual Residence of Deced 10a. State		-	Town or Location	n 10f. Zip Code			10g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 X No
or items	11. Marital Status 1 Never Married 2	12. Was Dec	2 X No	If Ye	s, specify Cubar Yes 2 χ No		o Rican, etc.)	White,	American Indian, Black,
ID 21215-0036 should be filed within 72 hours after and Mental Hygievich and Mental Hygievich and Mental Hygievich andric event, the Medical Examiner To Be Compoleted by	Elementary/Secondary (O-12) College (1 2		during mo	st of working life ate Con		tired)		of Defense
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Balti permit. Departm Importa	21 Signature o Funeral Se	rvice Licensee Ints Mo4516		22. Na 82	me and Address	s of Facility Lee ifer Lar	Funera ne, Owin	1 Home Ca gs, MD 20	lvert, P.A.
Physician /Medical Examiner	23a. Part I. Enter the disear failure. List only one of Immediate Cause (Final dis or condition resulting in dea Sequentially list conditions if any, leading to immediate	ause on each line. sease a Coronary A Due to (or as a b. Due to (or as a		oosis):	e mode of dying,	such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	UNPENDED IF FEMALE: 23b. Was decedent pregnar past 12 months? 1 Yes 2 No 9	t in the 1 Live bi	ant at time of dea	2 Feta	I death 3 er (Specify) _	Ectopic pregn	ancy	23d. Date of de Month	elivery Day Year
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fital Rec sician: The l is certificate lirector, page	examiner?	Hospital:	npatient 2 🗸 1	ER/Outpatient		of Death (Check	1 Yes	2 No 1	Yes 2 No
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Division C Hospital or Attent 1.24 hours after death Francial Directors etely filled in by the		determined (Specify) ng Physician: To the best	t of my knowledge	e, death occurre	d at the time, da	ate and place, and	or Town, §	State) se(s) and manner as	s stated.
To the He within 24 To the Fu Completel	29b. Signature and title of c	Examiner: On the basis of and manner strength	of examination an lated.	d/or investigatio	n, in my opinion 29c. Licens O.C.	e number	at the time, date		(Month, Day, Year)
der 10	30. Name and address of pe Laron Locke MD.	Assistant Medical		•	imore Stree	t, Baltimore,	MD 21223		
State Registra	E 50 50 70 70 70 70 70 70 70 70 70 70 70 70 70	(ear) 32. Re	gistrar's Signatur	8. par	Kel				

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DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend#8.PerFHPGC1-25-12cr Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:25 PM Sallie Mae Douglas January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Prince George's Laure Social Security Number 6. Sex 8. Date of Birth 10_30-46 **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🛣 Months Hours Anderson, S.C 65 **Director** 247-80-9253 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Prince George's Md Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5214 Addison Road 20743 U.S.A. items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces Black. White, etc , 0 1 Never Married 2 🙀 Married þ 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" Completed 3 Widowed 4 Divorced Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 years Office Manager D.C. Workers' Comp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o ည William Cullin, Sr. other traumatic Lula Mae Hawthorne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Douglas/Husband 5214 Addison Road, Capitol Hgts., Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ₹ of ... cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Maryland Nat'l.Mem.Park 01/21/12 Laurel, Maryland 22 Name and Address Picacilly ington & Sons Co. Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ pertension disease or condition vears Medical resulting in death) Examiner edrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami burlal-transi Cause (Disease or linjury that initiated events resulting in death) Last tery oronary /ears and Due to (or as a consequence of attending physician for use as the burla Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Obesity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Chronic Obstructive Pulmonary Disease 1 Yes 2 No 1 ☐ Yes 2 X No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D 28998 January 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saini 9101 Cherry Lane, Suite 211 Laure

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13, January 20°12 Randolph Jackson 6:05 aw Edwards Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number 6. Sex 8. Date of Birth (Month, Day, Y If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Maryland 219-30-3867 Director 79 1932 Usual Residence of Decedent or 28a-f show 10a State 10b County filed within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director MD St. Mary's Leonardtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21800 Paw Paw Point Way 20650 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o, þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumain. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Executive Search Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Edwards Harriet Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonardtown, Maryland Julia Edwards (Wife) P.O. Box 1822 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/15/2012 Brinsfield-Echols Charlotte Hall, MD 21. Signature of Funeral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Margaret H. Hicks M01631 22955 Hollywood Road Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDUP RESPIRATORY Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MASSIVE EMBOLISM VLMONAR Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause injury HEMMOILRHAGIC STROYE attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy performed' death? 2 🗹 No Yes 25. Was case referred to medical 쏊 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Vital Wards

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this

10 pme State

Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

069683

25500 Pt. Lookout Rd.

14/2012

Leonardtown, MD20650

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 17

LEONARDTOWN MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ed Malini, M.D.

Registrar's Signatu

			Please	Type or Pr	rint in I	Black Ir	ndelible In	k. Ens	sure A	II Copie	s Ar	e Legib	e.		
	_	For State		State of N	/larylan		artment of I		and M	lental Hy	gien	Э			
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Medic Examin		4a. Facility Name (if not					4b. City, Town, o	r Location		Januar		c. County of D		12.30	a ^{vi}
ŗ		Hospice o	of St.				Callaw					St. M		's	
Funeral Director		5. Social Security Numb 215 – 56 – 97	31 1	X M 2 □ F 7. A	ge (In yrs. Ia 61	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 10/24		50	Birthpl Countr	ace (State or For MD	eign
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tural", c	ted by	3 Widowed 4	Divorced	1 Yes 2 If Yes, Give Year or Dates.	- X No		I ☐ Yes 2 🔀 No		<i>:</i> :			Specify:	Bla	.ck	
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d be filed Aental Hyg irked oth tic event,		17. Father's Name <i>(First</i> Lester Cl		ridge						(First, Middle, ordon	Maider	Surname)			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name. Thomas J.	/Relationship (Ty) Spear	pe, Print) S/Son		19b. Mailir 1347	ng Address (Street Wilson	and Numb	er or Rural Wal	Route Number	er, City o	r Town, State	, <i>Zip</i> Co	ode)	
of He If item or othe		20a. Method of Disposit		Removal from Stat	20b. P	lace of Dispo	sition (Name of	eo),	D	ate	20c. l	ocation - City	or Tov	vn, State	
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Depar Impor any in		21. Signature of Funera	Service License	The			Name and Addre		-						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	in the past 12 mon 1 Yes 2 N 9 Unknown	nths?	1 Live Birth 4 Pregnant 9 Unknowr	at time of d		Ectopic pregnand Other (specify)	су		1		23d. Date of Month		Day Year	
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nysicia nis cer direct	To B	examiner? 1 Yes 2 N	<u> </u>	Hospital:	itient 2 🗆	ER/Outpatier	Oth			ne 5 🗆 Resi	dence	6 Other (S	pecify)	HOS PI	ce
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DHMH 17 Rev 7/2009

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of t	Jeani		2. Date of De	Reg. No	<u></u>	1	3. Time of Death
	Physicia Medio		John Henry East						Januar	y 23	, 201	ear 2	10:50 p.m.
	Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or		of Death		4c	. County of	Death	
	Euporol		Hospice House of St. Mary 5. Social Security Number 6. Sex 7. Aq	S je (In yrs. las	et hirthday)	Callaw If Under 1 Year		24 Hrs	B. Date of Birt	<u> </u>	St.		S lace (State or Foreign
	Funeral Director		578-46-0756 1 [™] 2 □ F	75	Yrs.	Months Days	Hours	Min.	(Month, Da 10/16/	Year)	6	Count	h Carolina
	od at	_	Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Loc	cation							Od. Inside City Limits
	farylar 8a-f s lified	Director	Maryland St. Mary's Mechanicsville										1 Yes 2X No
	the Na or 24		10e. Street and Number	rie	Chante	10f. Zip Code				10g. Cit	tizen of Wh	at Count	ry?
	h with ns 23, must 1	Funeral	39119 Birch Manor Drive										
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Beginnstart: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 2 Married 1 Yes 2 No								14. Race - Black, Specify:	White, e	tc.
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ē,	1 and of Heal item		Sandra K. East/Wife 20a. Method of Disposition	20b. Pla	ace of Dispo	Birch Ma		rive,			SVIII ocation - Ci		
<u>ii</u>	Page nent d ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	-	natory or other place em. Garden	· .	01/27	/2012	Wai	ldorf	. MD	
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of	ter this		27. Manner of Death 1 Natural 5 Pending (Month, Day)	ry 2	8b. Time of injury	28c. Injury	at at		d. Describe h			specity)	House
ion	the fu	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 🗆	No					
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T stice of	within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check Conly one) 3 Certifying Physician: To the best of Check Conly one) 3 Certifying Nurse Practioner: To the	xamination a	and/or investi	gation, in my opinio	n, death occ	curred at th	e time, date a	nd place.	and due to	the caus	se(s) and manner stated.
Ę	Mithii Company		29b. Signature and title of certifier	7		29c. License	number				te signed (N		
			· - 8VVV	\cup			005	シナ	> 1		-23	5-1	2
नि) pme		30. Name and address of person who completed cause of de Jennifer Schmidt, D.O. 40			rint) nts Lane.	Leon	nardto	own MI) 2	0650		
	Stat Registra	C	31. Date filed (Month, Day, Year) JAN 2 7 2012 32. Begistre	ar's Signatur	re .	ak							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month Day Dorothy January Magdaline Funkhouser 11:27 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fahrney-Keedy Home and Village Washington Boonsboro 8. Date of Birth (Month, Day, Jan. 21 **Funeral** vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Days Hours 99 **Director** 578-10-9749 1912 Georgia Usual Residence of Decedent or 28a-f show 10a. State within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 U.S.A. 8507 Mapleville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Specify: White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Pouncey Rosa L. Hindsman and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is <u> Marsha L. Politz/Daughter</u> 416, West Patrick Street, Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Stauffer Crematory 01/23/2012 Frederick, Maryland 21 Signature of Juneral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition numario Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Mass executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant Box 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Year 1 Yes 2 9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been signal 24b. Were autopsy findings available prior to completion of cause of death? Osteopowns 24a. Was an page performe certificate 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident
Suicide 1 Yes 2 No hours after death neral Director: A d filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Noise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier BC4871883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8507 mapleville Road, Boonsboro, Maryland 21713 Cantone NONT

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Donald Draper Frush 2012 20, January 2:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood of Williamport Williamport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F 89 217-12-1588 Sept. 21, 1922 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11322 Kings Valley Drive 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tooling Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hayes Frush Alma Anderson Draper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Frush/Daughter 11322 Kings Valley Dr., Damascus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2012 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel J. Mon 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ighs that caused the death. Do not inter the mode of dying, such as careful or respiratory arrest Approximate Interval Between Onset and Death one cause on each time Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is doorth), act Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions copyributing to death but of resulting in the underlying pause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1SUA 1 ☐ Yes 2 ᡚ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, P.O. signed by the a Division of Vital Records, page 2 Hospital or Attending Physician: The certificate After this certific funeral director, e Hosp.ru.. n 24 hours after death. he Funers! Director: Af.

Examiner Physician/Medical Completed by Be Certification: To Medical

Physician

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28a-f show

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item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "moleal Exp. "not shown that be notified.

72 hours after death with

Baltimore, Maryland 21215-0036

s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

Physician

/Medical

Pages 1

/Medical

		1 yes 2 No 1 Yes 2 No											
25. Was case referred to medical examiner?	26. Place of Death (26. Place of Death (Check only one)											
1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)												
27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Mork? 28c. Injury at Work? 1 1 Yes 2 No	28d. Describe how injury occurred											
3 ☐ Suicide 6 ☐ Could not 0 4 ☐ Homicide determined		f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, death occurred at the time, date and place, an iminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)											

29d. Date signed (Month, Day, Year)

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31. Date filed (Mont

29b. Signa

Registrar

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		4	For State of Maryla		artment of H tificate of D			eg, No. 2	12	02933
		-	Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h	Year	3. Time of Death
	Physiciai Medic	al .	Charlotte Glynn Flynn			I at Death	January	13, 20)12 Year	2:20 P M
	Examin	er	4a. Facility Name (if not institution, give street and number) Ginger Cove Health Center		4b. City, Town, or Annapo			Anne Arundel		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthi	place (State or Foreign htry)
à	Director		225-22-7540 1 □ M 2 🗓 F 87 Usual Residence of Decedent	Yrs.			2/20/1	924	Virg	jinia
	and show	ō		City, Town or Loc	cation				1	10d. Inside City Limits
	Maryl 28a-f otifie	irec	Maryland Anne Arundel	Ann	apolis 10f. Zip Code			10a Citizen of	1 ☐ Yes 2 🔀No tizen of What Country?	
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	is filed within 72 hours after death with the Maryland Hygiene. do lybgiene. do lybgiene. do lybgiene. do lybgiene. do went, the Medical Examiner must be notified at	Funeral Director	11 Marital Status 12. Was Decedent Ever in	U.S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert		ce - Americ		
20	after d I", or i xamin	þ	1 ☐ Never Married 2 【XMarried 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	L.	1 ☐ Yes 2 🏿 No			Specif		
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<u>o</u> E	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Kalas Cr	matory or other place cematory	1/		Edgewa		
Baltimore,	permit. Page Department of Important: It any injury or once.	3	21. Signatu of Fonera Substitution	22	2. Name and Address	ss of Facility Genons Isla	eorge P. and Rd. I	Kalas Edgewat	Funer er, M	ral Home ID 21037
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Div	ital or urs afte ral Dire		Bullang, vo. 154			- data and place			anner as st	rated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 X Certifying Physician: To the best of my leading to the complete	nation and/or inve	etigation in my onin	ion death occurre	d at the time, date:	and blace, and	due to the	Lausos and maine stated
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<i>→</i>			4a. Facility Name (if not institu	, •	number)	-	b. City, Town, or Cheverly	Location of Deat		4c. County of Prince Ge		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year	ar If Under 24Hr	s. 8. Date of E	Birth (MM/DD/YYYY)	Birthplace (State or	
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	the Mar or 28,	Director	6556 Bock T	Terrace			10f. Zip Code 2074	5		10g. Citizen of What Country? U.S.A.		
	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 Never Married 2		ecedent Ever in I		s Decedent of His	spanic Origin? (S	pecify Yes or N	Io- 14. Race - White,	American Indian, Black,	
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.			1 Yes	2 X No	1	Yes 2 x No		, , , , , , , , , , , , , , , , , , , ,	Specify:	Black	
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, M	and 2 sleath ar		Gary L. Freen 20a. Method of Disposition	nan/Son	20b.	6/19 I			ttsvill Date	Le, Marylar	nd 20784 Dity or Town, State	
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Baltimore,	permit. Departm Imports injury o		21. Signature of Funeral Servi	ce Licensee) 1 7 (1			of Washin	gton_&	Sons Co.	Inc. on, D.C. 20019	
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Divis	ospital or A hours after of ineral Directly filled in by	Certification:	3 Suicide 6 Co	ould not be 28e. Pla	ce of Injury - At h Major Roa	nome, farm, street	, factory, office bi	uilding, etc.	28f. Location (or Town,	Street and Number (State) ill Road, Oxon Hil	or Rural Route Number, City	
	e Hospital 24 hours e Funeral etely filled		29a. Certifier (Check only 1 Certifying	Physician: To the be	est of my knowled	ige, death occurre	ed at the time, da	te and place, and	due to the cau	se(s) and manner as	s stated	
	To the Ho within 24 h To the Fur completely	Medical	one) 2 Medical Example 29b. Signature and title of certification 29b.	caminer: On the basis and manner fier	of examination a stated.	and/or investigation	on, in my opinion, 29c. License		t the time, date		to the cause(s) (Month, Day, Year)	
			Pamel Fre	eithall. I	W		O.C.N			January 8, 20		
2	3	İ	30. Name and address of person Pamela E. Southall,		,	n 23a) Iminer 900	M/ Baltimore	Street Politic	more MD 3	1223		
		ate	31. Dat JAW 1018 2017	A	egistrar Signat		Datamore	. Olicet, Daitir	more, Miu Z	.1223		
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			For		State of	Marylan		artment of		and M	lental Hy	giene			
			State Registrar				Cer	tificate of	Death			Reg. No	201	2	02935
н	Dhysisis	. /	1. Decedent's Name	(First, Middle, L	.ast)				_		2. Date of De	ath Da	v Year		3. Time of Death
			Charles	3	Gran	son	Gr	imm			Januar		2012		10:55 A ^M
	Examin	er	4a. Facility Name (if n	ot institution, g	ive street and number	er)		4b. City, Town,	or Location	of Death		4c.	. County of De	ath	
-			15 St. Pa					Boons					Wash:	ing	ton
	Funeral		5. Social Security Nur		Sex 7.	. Age (In yrs. Ia		If Under 1 Year Months Days			8. Date of Birl (Month, Da	th y, Year)	9. B	ountry	ce (State or Foreign
			215-26-782 Usual Residence of D			85	Yrs.				Apr 20	, 192	26 Ma	ryl	and
	nd how at	'n		10b. County		10c. City	, Town or Loc	ation						10d	. Inside City Limits
	aryla 3a-f s ified	ect	Maryland	Washin	aton	Room	sboro								1 X Yes 2 □ No
	or 28	ä	10e. Street and Numb		gcon	рооп	SDOLO	10f. Zip Code			Т	10a. Cit	tizen of What (Country	?
	with t	era	15 St. Pa	9111 Str	aat			21	713				U.S.A.	,	
	eath tems	Funeral Director	11. Marital Status	IGI DEI	12. Was Decede			Vas Decedent of	Hispanic Ori	gin? (Spe	cify Yes or No-		14. Race - Am	nerican	Indian,
9	ter d	by I	1 Never Marrie	d 2 X Marrie		es? !□No 194	44-	Yes, specify Cul			Rican, etc.)		Black, Wh	ite, etc	
93	irs af Iral" I Exa		3 Widowed 4	Divorced	If Yes, Give Year or Date	s. 194	46 1	☐ Yes 2XIN	lo Specify:				Specify:	Whi	te
5-(2 hou "natu adica	Completed	(Speci	15. Decedent's	Education grade completed)		16a. Deced	ent's Usual Occi	pation	t of worki	na	16b. K	ind of Busines	s Indus	stry
21	hin 7: ne. than e Me	E O	Elementary/Secon		College (1-4	or 5+)	life. Do	O NOT use retire	d)		<i>'</i> 9				
121	d wit lygiel ther i	Be C	5				Dock	Worker	1				Transp	orta	ation
and	e file ntal H ed of ever	To B	17. Father's Name (Fi		•				1		(First, Middle,	Maiden :	•	_	
3	nerra nerra netto		Lester		Gri	mm	1			Vada			Beach:	ley	
Mai	shol h and 7 is r traun		19a. Informant's Nan	•			1	g Address (Stree							
	and 2		Esther E. 20a. Method of Dispo		/ wite	001- 0	•	t. Paul	Stree						21713
jor			1 🔀 Burial 2 🗆	Cremation 3	☐ Removal from St	tate c	emetery, cren	sition (Name of natory or other pl			ate	20c. Lo	ocation - City o	or Iowr	n, State
ţi	t. Paq tmer rtant njury		4 Donation		ecify)	Boo		Cemeter			/2012				Maryland
Bal	permi Depar Impo any ir		21. Signature of Fure	WEEN.	Dell	2/	7	. Name and Add 606 01d	Nation	nal 1	Pike B	oons			ome, PA 21713
i in	Physician/		23a. Part 1. Inter the shock in heart Immediat. Cause (Fi	inal	emplication that ca y one caus theat	sed the death line.	n. Do not ente	r the mode of dy	ing, such as	cardiac o	r respiratory an	rest,		lr O	pproximate iterval Between inset and Death
€	Medical		disease or condition resulting in death) a. Unumonum Due to (or as a consequence of):										7	weeks	
2.6	Examiner	L	Coguentially list con	ditions	. li	hinal	Ster	10525						4	ears
	_ +	Sequentially list conditions, if any, leading to immediate Due to rais a consequence Sector leaders in the conditions.	as a consequ								ľ				
	cuted nd ransi	хап	that initiated events	njury	c	ezeni	rain	ie on	10017	n				1	jeans
	e execian a	E E	resulting in death) La	ast	Due to (or	as a consequ	ence of):							/	110001
9	ate be hysic the bi	edical			■ d. <u> </u>	aau	ev_	Como	w					\vdash	years-
387	irtifica ling p e as t	/Me	IF FEMALE:		222 15 112 215					-					
×	th ce	Physician/M	23b. Was decedent p in the past 12 m			rth 2 🗌 Feta	Ideath 3	Ectopic pregna	ncy				23d. Date of d Month	lelivery Da	ay Year
B	e dea the a hed f	ysic	1 Yes 2 U	No	4 ☐ Pregna 9 ☐ Unknov	nt at time of d wn	eath 5 L	Other (specify)					WOILL	0.	ly real
P.O.	at the		Part II. Other signific	ant conditions	contributing to dea	th but not resi	ulting in the u	nderlying cause	given in Part	1.	23e. Did to	obacco u	use contribute	to the	cause of death?
Ϋ́,	signe	Completed by		Ath	nsclus	35					1 🗆	Yes 2	□ No 3 □	Probab	oly 4 Inknown
ğ	requi	ete		N.10	he and	esus 4	n				-				findings available
၁၃	has law	mp		MO VI	110 01 -	1					24a. Was autor			comp	eletion of cause of
Ä	In by the funeral director, page 2 should be detached for use as the burial-transit		25. Was case referred	4 +1:1							1 Tes	2 N			□ No
ita	siciar certif recto	Be	examiner?	P	Hospital:			To	Place of Dea			\leftarrow			
5	Phys	<u>ان</u>	27. Manner of Death	400	1 ☐ In 28a. Date of	patient 2 injury	ER/Outpatier 28b. Time of	t 3 DOA 28c. Inji	4 ∐ Ni		me 5 Resid			ecify)	
n o	ding th. After fune	Certificate:	1 Natural 2 Accident	5 Pending	(Month,	Day, Year)	injury	wo	ork? ☐ Yes 2 ☐		tod. Describe r	iow injury	y occurred		
Sio	Atten deal ctor: y the	rţįį	3 Suicide	6 Could no	t be	f Injury - At ho	me, farm, stre	et, factory, office			28f. Location (\$	Street and	d Number or F	ural Ro	oute Number
×	after Dire		4 ∐ Homicide	determine		, etc. (Specify,		, , , , , , , , , , , , , , , , , , , ,			City or Tox			i car car i i c	oute rumber,
П	spita hours neral 1 fillet	Medical	29a. Certifier 1)	Oortifying P	hysician: To the bes	t of my knowle	edge, death o	ccured at the tin	ne, date and	place, and	d due to the ca	use(s) an	nd manner as s	stated.	
	n 24 l	Ned	(Check 2 L	_ Medicai Exa	miner: On the basis urse Practioner: To	of examination	and/or invest	igation, in my opi	nion, death o	ccurred at	the time, date a	and place	, and due to the	e cause	e(s) and manner stated. d.
	To the To the COTE		29b. Signature and til												
				17	7			0	449	96	·	10	invar	4	23,2011
-1 .			30. Name and addres	ss of person wh	o completed cause	of death (Item	23a) (Type, P	rint) 20 211	1 als	nar	20	n.	and-	, n	23, 2011 23, 2011
W				1 11 11	10101010			-0 3//	11		6	1900	erise r il	, ,	0-115
			31. Date filed (Month,	JANEZ E	ZU12 32. Re	istrar's Signat	ure .	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\text{Year}}{12}$ 4:00 AM Margaret R. Garrett January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 9. Birthplace (State or Foreign Country)
Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** March 8 1 □ M 2 🕅 F Months Hours 91 Yrs. Director 220-09-3706 1920 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Washington Hagerstown ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 10928 Hartle Drive 21742 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. within 72 hours after 1 ☐ Yes 2 🔀 No Specify. White Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Secretary Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ralph Reid Genevieve Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Garrett/Son 10928 Hartle Drive, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Park 01/19/2012 Rockville, MD 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licensee Heran MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 6 months Adult Failure to Thrive Medical Due to (or as a consequence of) **Examiner** Advanced Dementia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Protein Calorie Malnutrition, Esopagitis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Mylo hysplasia, chronic anemia, Osteoporosis 24a. Was an autopsy performed? Yes 2 No Hypertension, B12 deficiency 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Records, Division of Vital ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th npleted filled in by

Baltimore, Maryland 21215-0036

Box 68760

Registrar

(Check only one)

31. Date filed (Month, Day, Year) **JAN** 20

> A Rebert Dischbacker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

H. Robert Birschbach, MD, 201 Russell Avenue, Gaithersburg, MD 20877

1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

04115

January 17, 2012

rank Charles Gio	vane
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day January 22, 2012 **Medical Examiner** 1124 hrs Frank Charles Giovane 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death New Carrolltion Carrollton 8309 Larchwood Street Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 1^X M Country Maryland 591-28-9753 42 03/22/1969 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1 Yes 2 No 28a-f shov items 23a or 28a-f sho ust be notified at once. Director MD death with the Maryland Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20784 8309 Larchwood Street USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Yes permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner... If Yes, Give Year 3 Widowed 4 Divorced Yes 2 No specify: White Specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Estimator Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Frank Joseph Giovane Elizabeth Anne Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 576 Glebe View Lane, Lottsburg, VA 22511 Elizabeth A. Giovane / Mother 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Baltimore, Date 20c. Location - City or Town, State crematory or other place)
Brinsfield-Echols
Crematory 4 Donation 5 Other Specify 01/27/2012 Charlotte Hall, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Road, Charlotte Hall, MD 2062 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** een Onset and /Medical Death a Methadone Intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical $_{ imes}$ AMENDED 23a,27,28a-f,per me,g924 2-8-12 sm 4b perme g925 3-28-12 vt 28f X UNPENDED the attending physician ed for use as the burial requires that the death certificate be Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a, Was an 24b. Were autopsy findings available plet The law r autopsy prior to completion of cause of certificate has l Som Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Natural unknown 5 Pending 1 Yes 2 X No Director: death. fd 1-22-12 fd 1100 hrs 2 Accident o 24 hours after de Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town (\$46) 8309 Larchwood St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 ___ Suicide 6 X Could not be determined (Specify) Homicide residence lew Carrollton MD 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 23, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Fegistrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1	For State of Maryland / Department of Registrar Cer	tificate of Death		g. No. 2012	02938		
H	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	1 ^{Day} , 2012	3. Time of Death 11:40 AM		
	Medic Examin	al .	Jean Elizabeth Groff 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January	4c. County of Death			
	LAdilliii	CI	NMS Healthcare	Hagerstown			Washington		
	Funeral Director		5. Social Security Number 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y March 20	(ear) 1931 Mary	nplace (State or Foreign ntry) Y Land		
	land show dat	- 1	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits		
	e Mary r 28a-f notifie	Direc	Maryland Frederick 10e. Street and Number	Frederick	10	ng. Citizen of What Cou	1 Nes 2 No		
	with the	Funeral Director	6411A Quinn Road	21701		USA			
936	s after death al", or item: Examiner m		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:			
Baltimore, Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of work 10 NOT use retired) Bookkeeper	6b. Kind of Business I				
od 2	filed wir al Hygie d other went, tl	Be	17. Father's Name (First, Middle, Last)	i	e (First, Middle, Ma				
ylaı	uld be I Menta narkec natic e	욘	Earl Bowers	Ma	deline W		Cadal		
<u>a</u>	12 sho alth and 27 is r r traun		19a. Informant's Name/Relationship (Type, Print) Eric Groff / Son 19b. Maili	allA Quinn Rd., Fr	ederick,	MD 21701			
ore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State 20b. Place of Disposition cemetery, cre-	matory or other place)		20c. Location - City or			
Ħ Ħ	nit. Pag artmen ortant: injury e.			er Crematory 1/1 2. Name and Address of Facility	8/2012 Stauffer	Funeral H	ome		
ñ	Dep Imp		I pustney Staully	1621 Opossumt	own Pike	, Frederic			
	Physician/		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure, list only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a consequence of): Della vala.	570					
	_ #	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a con-equence of):						
	rate be executed physician and the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of):						
0	e be ex ysician e buria	lical	d. Prenoma						
Box 68760	th certific ttending or use as	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year		
s, P.O.	iires that the dea n signed by the a Id be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	the cause of death?		
Division of Vital Records, P.O.	sician: The law require certificate has been si lirector, page 2 should l	Completed			24a. Was an autops perform	y prior to death?	topsy findings available completion of cause of s 2 No		
ital	ician: Dertifica	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient	26. Place of Death (Chec		- C - C			
n of V	Attending Physician: The la en death. ector: After this certificate ha by the funeral director, page	cate: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury		28d. Describe ho	nce 6 Other (Spec w injury occurred	enty)		
Jivisio	al or Atten s after deat I Director: d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Str City or Town,	reet and Number or Ru , State)	ral Route Number,		
_	To the Hospital or within 24 hours after To the Funeral Dir completed filled in	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of the contr	stigation, in my opinion, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.		
_	withi To th		29b. Signature and title of certifier	29c, License number DOCTAY2		9d. Date signed (Mont			
			30. Name and address of person who completed cause of death (Item 23a) (Type,		0.0	1/16/2012			
	3		Noor Siddiqui, MD 324 East Antie		lagerstow	n, MD 2174	0		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barre					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 Ⴖ . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 1⁹ 2012^{ea} 6:10 P_{M} Pinkie Green Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick 2015 Baythorne Road If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 □ M 2 😾 F 06/25/1917 Maryland 577-09-8876 94 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Prince Frederick Maryland | Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Baythorne Road 20678 United States 2015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Mental Hygiene. narked other than "natural", or i 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes If Yes, Give 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Beauty marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Pauline Ruby Fields Gilbert Owen Rhine permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Baythorne Road, Prince Frederick, MD 20678 Oliver F. Green / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Metropolitian Crematory 1/20/2012 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, 21. Signature of Funeral Service Licensee 4405 Broomes Island Rd., Port Republic, MD 20676 M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phylician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin executed Cause (Disease or linju that initiated events resulting in death) Last and trar Due to (or as a consequence of): physician are sthe burial-t Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death the 9 Unknown 9 Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ es 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 K Residence 6 Other (Specify) Director: After this in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. rpleted filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 h To the Fun (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

LRW

Registrar

29b. Signature and title of certifie

JOSEPH JOHN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 23

32. Registra Signature

0522

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Allen Hawk 2012 3:07 A M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number 6 Sex If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** Months Days Hours (Month, Day, Year) Director 514-34-0535 Usual Residence of Deced 1 ▼ M 2 □ F 76 Oct. 11, 1935 Kansas 28a-f shov 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 No MD Prince George's Bowie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3503 Mullin Lane 20715 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc 0 þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 No 1 ☐ Yes 2 ₩ No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Industrial Psychologist Department of Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert John Hawk Ruth Glee Harvey Jet 1 and 2 sh. Jet 1 and 2 sh. Jet 1 and 2 sh. Important: If item 27 is many injury or other 2 once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chiyoko Hawk/Wife 3503 Mullin Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 F Cremation 3 Removal from State Metro 1-20-2012 Crematory Baltimore. 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ances disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ξ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 🗌 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier dertifying lurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29q. Date signed (Month, Day, Year) 1116112

DHMH 17 Rev 06-2011

State Registrar 30. Name and add

MUZUN 31. Date filed (Month

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Suite ZIV ANDIPONS MO

Completed cause of death (Item 23a) (Type, Print)

2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eri Ann Harbou		amend #1&1§	tate of Maryta		artment of rtificate of		d Menta	l Hygiene	Dan No	201	2 1294
Physicia	an/	Registrar 1. Decedent's Name (First, Midd H2	lle,Last) arbaugh					Date of D Month	Day	Year	3. Time of Death
Medical Exami	ner	Teri Ann Ha 4a. Facility Name (if not instituti	rbough	nber)		4b. City, Town, or	Location of F	January	24, 2012	ounty of Dea	1159 hrs
		45770 Church Drive		,		Great Mills				Mary's	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea Months Days		Min		Fore	sirthplace (State or
Director		177-50-5640 Usual Residence of Decedent	1 M 2 X F	5	3 Yrs.		, Hours	July	15, 19	58 c	country) PA
u		10a. State 10b. County			Town or Locati						10d. Inside City Limits
Maryland 28a-f show i at once.	5	MD St. I	Mary's	Gr	eat Mil —	ls					1 Yes 2 X No
e Mary or 28a-	Director	10e. Street and Number	D .	100		10f. Zip Code		· ··· -	10g. Citizen	of What Co	untry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.		45770 Church 11. Marital Status		ot. 102 Ident Ever in U.	.S. 13, Wa	20634 s Decedent of His	panic Origin	? (Specify Yes or		ed Sta	ates erican Indian, Black,
death or item	Funeral	1 Never Married 2 N	Married Armed For	rces?		es, specify Cuban				White, etc.	,
s after iral",	2	3 Widowed 4 X Dir 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates:			Yes 2 X No		d at made days			White
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)				ost of working life.			10D. KING	d of Business	s/industry
0036 within ene.	Ē		2		Dis	sabled					
:15-00 a filed with ced other at, the Ma	Be C	17. Father's Name (First, Middle Lowell Edwin	Brame1					lame (First, Middle y Marie	,	,	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than nmartic event, the Medica		19a. Informant's Name/Relations			19b. Mailing	Address (Stree					te, Zip Code)
imore, MD 2 Pages I and 2 shoulment of Health and Intent of Health and Intent If item 27 is no or other transmatic		Kimberly Rohre 20a. Method of Disposition	er (Sister)	1 20h I		North Me	_	ane, Leo			20650 or Town, State
Baltimore, MI permit. Pages I and 2 Department of Health a Important: If item 27 injury or other tranm		1 Burial 2 X Crematio	_	m State	crematory or oth	er place)	·			•	,
Baltimo permit. Page Department o Important:	-	4 Donation 5 Other S 21. Signature of Funeral Service		Br:		d-Echols ame and Address		1/28/201 rinsfiel			e Hall, MD
Dep Dep M		Danielle Ward	1 мо1403	eveno		955 Holl					
Physician /Medical		23a. Part I. Enter the disease, of feilure. List only one cause	on each line					iac or respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive			ovascular Dis	ease				Death
		Sequentially list conditions,	b								
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.								
ted nsit	Exa	events resulting in death) Last	Due to (or as a d	consequence o	f):						7
be executed be isician and urrial - transi	dical	UNPENDED	d AMENDED		_					_	
	/Mec	IF FEMALE: 23b. Was decedent pregnant in t	h	utcome of pregi	nancy				23d. D	ate of delive	ry
	ician	past 12 months?	4 Pregna	th int at time of de		aldeath 3 [ner <i>(Specify)</i>	Ectopic pr	egnancy	Mo	onth	Day Year
hed hed	Physician/Me	1 Yes 2 No 9 V Un	o _ oracle			-		[00- P:			
P.O. es that the igned by the detach	<u>اھ</u>	Part II. Other significant condi	tions contributing to	death but not re	esuiting in the u	nderlying cause g	iven in Part I.				o the cause of death?
cords, P.O. law requires that has been signed b	Completed							24a. Wa			utopsy findings available
(eco	d Ho							per	topsy rformed? s 2 No	death?	
1 of Vital Records, ling Physician: The law requir After this certificate has been si funeral director, page 2 should I	Be	25. Was case referred to medica examiner?						eck only one)			
of Vition Physical After this	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 In	patient 2	ER/Outpatient 28b. Time of Ir		Other ₄ N	ursing Home 5	Residence	6 Othe	er: Scene
F # . ~ 4	Certification:	1 Natural 5 Pen	(Month, I	Day,Year)	200. 11110 01 11		es 2 No		o non injury	zodirod	
Division spital or Attenditions after death.	tifica	3 Suicide 6 Cou	id not be	of Injury - At ho	ome, farm, stree	t, factory, office b	uilding, etc.	28f. Location or Town		Number or R	tural Route Number, City
Divi ospital or hours after aneral Dir y filled in		4 Homicide	ermined (Specify)								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only	hysician: To the best aminer:On the basis of	examination a							
8 4 8 4	₩.	29b. Signature and title of certifi	and manner sta er	itea.	1	29c. License	number		29d. Date	e signed (Mo	onth, Day, Year)
		ler Cu	111	/	7	O.C.N	∕I.E.		Januai	ry 25, 201	12
10 pine	ſ	 Name and address of person Zabiullah Ali, M.D. 	n who completed cause Assistant Medica		-,	altimore Stree	et. Baltim	ore. MD 2122	3		
	ate	31. Date filed (Month, Day, Year)		istrar's Signatu	ire				-		
Regist		JAN 2	7 2012	nova		wed					OCME
DHMH 17 Rev 1/20	001				ORIĞINAL	_				C	CME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January Mildred Wicke Hinkle 2012 1:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4559 Sixes Road Prince Frederick Calvert Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

01/19/1913 9. Birthplace (State or Foreign 1 M 2 🖫 Director 131-20-4492 New York 99 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified any ones. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Maryland Calvert 1 Yes 2 No Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 Epworth Ct. 20688 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify: 3 X Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry W. Wicke Gretchen Hittmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Mehosky / Daughter 4830 South Lane, St. Leonard, Maryland 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 01/24/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA
4405 Broomes Island Road, Port Republic, MD 20676 Kyle S. Simons MO1206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: $_4$ \square Nursing Home 5 \square Residence 6 \times Other (Specify) Hospice 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred House 1 Natural injury 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical

State

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009 29a Certifier

(Check

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

h19>

JAN 23

32. Registra s Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beverly Ann Harwood January T9 2012 7:20 Рм Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3245 Adelina Road Prince Frederick Calvert 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F 579-48-2606 Director 79 0270871932 Kentucky Usual Residence of Decedent 28a-f show 10c. City. Town or Location must be notified at 10d. Inside City Limits Director Virginia Fairfax 1 Yes 2 TNo Annandale 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8814 Stark Road 22003 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Force ò δ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 'natural", Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of ပ္ Dale Jones Mary Evelyn West ge 1 and 2 should be nt of Health and Mer :: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Harwood / Son 7806 Sycamore Dr., Falls Church VA. 22042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 01/21/2012 Alexandria, Virginia 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Department of Important: If 22. Name and Address of Facility Rausch Funeral Home, Signature of Funeral Service Licensee Kyle S. Simons M01206 4405 Broomes Island Road, Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Diabetes Mellitus Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Dementia Alzheimer's Type use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 → No
9 ☐ Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown P.O. I s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 👺 Natural 5 Pending work? Accident Investigation 2 No completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D45092 01/20/2012 who completed cause of death (Item 23a) (Type, Print) Rince Frederick Blad Ste 101, 1 Rince Frederick, MD 206 18 Registra Signature State Registrar

DHMH 17 Rev 7/2009

	ι		For State Registrar	State of M	laryland /	-	artment of F		nd Mer		ene20	12	029	4
u	Dhi.ai		1. Decedent's Name (First, Middle, Last)							Date of Death Month	Day	Year	3. Time of De	ath
	Physici /Medic	al			ris Jun	e Hoi				January			1:30 P	М
1	Examin		4a. Facility Name (If not institution, give)		4b. City, Town, o				4c. County			
			Golden Living Cer			1 1 4 1 1	Ha If Under 1 Year	gerst		Data of Birth			ngton	To an imm
H	Funeral Director		5. Social Security Number 6. Sec 12 19 - 12 - 12 3 3	M 2017. A	ge (In yrs. last 87	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, ec. 20,	Year) 1924		nplace (State or F untry) laryland	oreign
	p .		Usual Residence of Decedent		10c. City, T	own or Lo	antion					<u>1</u>	10d. Inside City I	Limits
	aryla •hov	2	10a. State 10b. County		Too. Oity, 1	OWIT OF LC	Cation						1∑Yes 2	
	88e-f	Director	PA Frank.	lin			Wayne 10f. Zip Code	sboro		11	Og. Citizen of V	What Co		
	with t	급	10e. Street and Number 311 S. Church St	D O	Box 79	0		268		1 "	U.S		arkty.	
	s 23	eral		12. Was Deceden					in? (Specify	v Yes or No-			rican Indian,	
30	n 72 hours after death with the Maryland *natural', or Items 23a or 28e-f ehow adical Examinar must be notiliad at	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 [X] If Yes, Give	? [No	į.	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2፟፟∰ No		Puèrto Ric	an, etc.)	Blac Specify	k, White	n.etc. Thite	
215-0036	tural'		3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edu	Year or Dates:		6a Dece	dent's Usual Occup	ation			16b. Kind of Bu			
۲ ک	n 72 nal	Completed	(Specify only highest grad	e completed)		(Give	kind of work done OO NOT use retired	during most	of working		160. Killa of Ba	311103371	industry	
2	within lene. then	E	Elementary/Secondary (0-12)	College (1-4or	5+)		Seamstr	ess			Knit	ting	Mill	
S S	filled Hygi other	0	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	irst, Middle. N	Maiden Sumam	Θ)		
Maryland	ld be ental ked c	To B	Jesse Brown	1					Marg	gie Bro	own			
<u>~</u>	s 1 and 2 should f Health and Men Item 27 ie marke other treumatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	31	19b. Mailir	ng Address (Street	and Number	r or Rural R	oute Number	City or Town,	State, Z	tip Code)	
	1 and 2 Health a tem 27 te		Cindy A. Warner	(Daughter	r)	311S	. Church	St. Po	o.Box	790 Wa	aynesbo	ro,	PA 1726	8
ē,	s 1 a of Hez item othe		20a. Method of Disposition		com	e of Dispo	sition (Name of matory or other place	ce)	Date		20c. Location -	City or	Town, State	
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	8		rg Cremat		Janua 18, 2	2011	Smiths	burg	, Maryla	and
altimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fureral Service Licens	88	MO14	14 22	2. Name and Addre	ss of Facility	y J.1	L. Davi	s Fune.	ral	Home	
ñ	90 1 20		1 John Lee	1) wis		12	2525 Brad	bury A	Ave. S	Smiths!	ourg, M	aryl	and 217	83
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that cause	ed the death. I	Do not ent	er the mode of dyir	ng, such as c	cardiac or re	espiratory arre	est,	11	Approximate Interval Betwe	
	Physician		Immediate Cause (Final disease or condition			11 01/	440						24 hou	
7	/Medical		resulting in death)	Due to (or a	s a consequen	ice of):	moi m dese						-	
	Examiner		Compatible list conditions	b	alsh	en	no dese	are					5 years	•
	D #	ner	S uentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a con wer	ice of):								
	ecute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	o								-		
Ö,	ate be executed thysician and the burial-transit		resulting in dodain, cast	Due to (or a	s a consequer	ice or):								
8/60	certificate be executed Iding physician and Ise as the burial-transit	dical		d										
× e	eath certific ettending p for use as f	by Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregnancy	v					23d. Da	te of del	nunc.	
Rox	eath e	lan	in the past 12/months?	1☐Live birth	2 ☐ Fetal de at time of deat	ath 3[Ectopic pregnanc	У				nth	Day Ye	ar
o.	by the de	yslc	1 □ Yes 2X No 9 □ Unknown	9□ Unknown	at into or doub		_ calor (apoonly) _							
<u> </u>	res thet igned by be deta	y P	Part II. Other significant conditions co	ntributing to death	but not resulting	ng in the u	nderlying cause gr	ven in Part I.		23e. Did tol	pacco use cont	ribute to	the cause of dea	ath?
Sp	uires n sigr ald be									1 □ Ye	s 2 No	3 □ Pr	obably 4 Dun	known
Records,	law requires thet the death as been signed by the etter 2 should be detached for u	Completed								24a. Was a		Were au	itopsy findings av	/ailable
	sicien: The law certificate has b irector, page 2 s	E C								autops perform	med?	prior to death? 1 □ Yes	completion of cau	ise of
Viital	en: j	BeC	25. Was case referred to medical					26. Place	of Death (0	Check only on			24,10	
>	ysici is cer direct	ToB	examiner? 1 □ Yes 2 □ A	Hospital: 1 ☐ Inpa	tient 2 EP	VOutpatie	nt_3 DOA Ott	205			ence 6 Oth	er (Spe	cify)	
0	g Ph ter th		27. Manner of Death	28a. Date of In (Month, D	jury 28	Bb. Time o	f 28c. Inju Wo	ry at	280	d. Describe h	ow injury occur	red		
ō	ttsnding I death. ctor: After y the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , ,	,,		Yes 2□N	No					
Division of	of or Attanding Physicien: after death. I Director: After this certific d in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	njury - At home etc. (Specify)	e, farm, st	reet, factory, office		281	Location (Si City or Town		er or R	ural Route Numbe	Эг.
	itel o irs aft rel Di	Cer					-0-0-11							
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam		of examination									
	To th Within To th compl	Me	29b. Signature and title of certifier				29c. Licen:				9d. Date signe			
			Mayeus	suces	_		02	\$365	-		1-15	12		
	1 br		30. Name and address of person who c	ompleted course of	f death (Item 2		Print)	5.0	0.0		1-15 eyoter			
			MAWZAR.	DS140	RR1		368 re	ell.	Hu	1- 14c	Syster	ur	10 2/7	140
	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signatur									
	Regist	rair	FEB 0 3 2012	men o	. sgar	-					4115			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	eartment of Health and leartificate of Death	, ,	2012 02965					
			Decedent's Name (First, Middle, Last)	ranoate or Beatin	Reg. 2. Date of Death	3. Time of Death					
	Physicia Medio		Melody Ann Jones		Month January C	Day 2012 10:15 P.M					
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
	Euroval		13610 Town Farm Road 5. Social Security Number	Upper Marlboro If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince George's 9. Birthplace (State or Foreign					
	Funeral Director		218–66–9733 1 □ M 2 M F 54 Yrs.	Months Days Hours Min.	(Month, Day, Yea 06/02/195	country) Wash., D.C.					
	oo te	ī	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits					
	larylar 3a-fsl ified	Director	Md. P.G.			1 🔀 Yes 2 🗆 No					
	the M	l Dir	10e. Street and Number	Marlboro 10f. Zip Code	10g.	Citizen of What Country?					
	h with ns 236 nust k	Funeral	13610 Town Farm Road	20774		U.S.A.					
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black					
7	72 ho in "nai Medici	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b	Kind of Business Industry					
212	within giene. er tha , the l			retary	Ce	ensus Bureau					
Maryland	should be filed n and Mental Hy is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Unknown		ne (First, Middle, Maide Narie Davis						
Mar	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e	or Town, State, Zip Code)									
	and 2 Healt tem 2		Gregory A. Jones, I/ Husband 13610 20a. Method of Disposition 20b. Place of Disp	O Town Farm Road, L		coro, Md. 20774 Location - City or Town, State					
D E	Page 1 nent of ant: If i		M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	matory or other place)		uitland, Maryland					
Baltimore,	permit. Page 1 Department of Important: If i any injury or conce.					s Co., Inc. shington, D.C. 20019					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Pnysician/		Immediate Cause (Final disease or condition	Cancer		Interval Between Onset and Death					
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.								
_	certificate be executed inding physician and use as the burial-transit		resulting in death) Last Due to (or as a consequence of):								
760	icate b	edical	d	<u>-</u>							
Box 68	death	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
P. O.	The law requires that the ate has been signed by the page 2 should be detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?					
	uires the signeral si	ed by			1 🗆 Yes	2 No 3 Probably 4 Unknown					
Sorc	tw requals been 2 shou	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
Ř	sician: The law r certificate has b irector, page 2 s	Com			performed 1 Yes 2	death?					
<u>ra</u>	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Chec	k only one)						
<u> </u>	> .º '0	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	f 28c. Injury at	ome 5 Residence 28d. Describe how in						
00	ending eath. or: Afte	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	·						
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)					
בֿ	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	nd due to the cause(s)	and manner as stated.					
	o the Hospital of thin 24 hours a the Funeral Dompleted filled in	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	it the time, date and pla	ice, and due to the cause(s) and manner stated.					
	To the within 2 To the comple		29b. Signature and title of certifier Jocelyne Kouchthou, M.D.	29c. License number		Date signed (Month, Day, Year)					
Ž) M		30. Name and address of person who completed cause of death (Item 23a) (Type,	A63748	01,	/12/12					
12	, 1		Jocelyne Kouatchou, M.D. 4041 Powder Mi		lverton.Ma	ryland 20705					
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registrar's Signiture			<u> </u>					
	- region c										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Matilda KAMARA 9:57 PM IANUARY Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea
June 20, 216-73-4765 Director 1 🗆 M 2 🕱 F 66 Yrs. 1945 Sierra Leone Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Maryland Washington Hagerstown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21740 1056-H Noland Drive Sierra Leone Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ black 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) her own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adira Akpan Abu Kamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Kamara - son 1056-H Noland Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 2/4/2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen: 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 (1Con 120 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opert and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in death). Last Examine resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Lugis 457 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner burial-transit and attending physician or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as for be detached signed by peen has after death.

Director: After this certificate director, funeral

28a-f shov

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items 23a

er than "natural", or ite the Medical Examiner

I Hygiene.

and Mental Hygier is marked other t traumatic event,

permit. Page 1 and 2 should be Department of Health and Ments Important. If item 27 is marked any injury or other.

Maryland 21215-0036

altimore,

must be notified at

Certificate: To Be Medical

28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 \square Pending 1 Natural work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

29c. License number

29d. Date signed (Month, Day, Year,

20-1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1122

31. Date filed (Month, Day, 32. Resistrar's Signature

State Registrar

filled in by the

only one) 29b. Signature and title of

within 24 hours a Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **2:55** P. M Physician/ Mildred Mary Keesee 2012 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Hospice House Calvert Frederick Prince 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Min. 1 - M 2x F Director 214-36-3018 71 Nov. 15, 1940 Washington, D.C. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Chesapeake Beach Calvert 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3312 Silverton Lane 20732 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 I Hygiene. other than "natural", 1 ☐ Yes 2 ☐ No Specify: 3 🗆 Widowed 4 🙀 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Settlement Officer Mortgage permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ Kenneth Murray Wemann Mildred Irene Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Silverton Lane, Chesapeake Beach, MD 20732 Lori Keesee/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licens 22. Name and Address of Facilit Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Efter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events resulting in death) Last physician ar s the burial-tr Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 use as 23c. If yes, outcome of preg*n*ancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atter in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Pregnant at time of death P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has the director, page 2 s autopsy perform death? rmed? 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: မ 4 Nursing Home 5 Residence 1 Inpatient 2 I ER/Outpatient 3 I DOA this nours after death.

neral Director: After this filled in by the funeral d 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practiceer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 7 d cause of death (Item 23a) (Type, Print) drw d Tren MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24, 2017 Physician/ **Honth** 4:05 M Samary Mason Peter LUKE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Meritus Medical Center Hagerstown Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days 110-68-0479 **Director** 1 🗶 M 2 🗆 F 97 May 13 1914 Dominica Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1X Yes 2 ☐ No Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral items 23a 21740 USA 123 Garlinger Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Black "natural", 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 Road Supervisor should be filed with and Mental Hygier 7 is marked other the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or a significant in the significant in th မှ Mignonette Jude Joseph Luke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Garlinger Avenue, Hagerstown, Md. 21740 Martha Luke - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cemetery 2/4/2012 Garfield, New Jersey 21. Signature Wuneral Se Minnich Funeral Home 22. Name and Address of Facility the 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rectal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) FIBRILATION **Examiner** ATRIA Sequentially list conditions Examine if any, reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit and Due to (or as a consequence of): resulting in death) Last physician To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the huminal deaths of the season of the huminal director. Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗗 No 1 Inpatient 2 ER/Outpatient 3 DOA |ဇ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1. Natural 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Lertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25/12 A 2 12 MOHANN+"D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Mohammed

31. Date filed (Month, Day, Year)

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JAN 25 2012

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egistrar's Signatur

11116 Medical Campis Rd. Hazzistam, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02949 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 2012 4:15 p.m. John D LeRoy Jr. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 18337 Hartman Drive Lexington Park Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Min (Month, Day, Year, Director 562-54-0547 1 🛛 M 2 🗆 F Alabama 94 05/10/1917 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Examiner must be notified 1 Yes 2 X No Maryland St. Mary's Lexington Park ā o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20653 16161 Point Lookout Road , or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify. "natural" Completed 3 X Widowed 4 Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 1 Officer U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) n and Mental H ၉ Emily Ada Cookston John D LeRoy 1 and 2 should to the strand Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Long/Daughter 12999 Mills Creek Drive, Lusby, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 Department of Important: If it any injury or o ō 1 X Burial 2 Cremation 3 Removal from State Episcopal Cem 01/28/2012 | St. Mary's City, MD 4 ☐ Donation 5 ☐ Other (Specify) Seric ice see Brinsfield . Signature of theral 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line erval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). Exami and -trar that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buris Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) signed by the a g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? performed? Yes 2 X No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Friend's fy)Residence Other: 4 Nursing Home 5 Residence 6 X Other (Spec Hospital: 2 XNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) XNatural 5 Pending 1 Yes 2 No death. M __ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after within 24 hours a Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D0031563 January 24, 2012

(4) pmu State

Registrar
DHMH 17 Rev 06-2011

20945 Great Mills Road, Lexington Park, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles M. Benner, M.D.

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 201^{Year} 9:30 A. M January Elizabeth E. Latimore Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg 7512 Elioak Terrace If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Min. 1 🗆 M 2 🔀 F 340-14-0918 Director 03/28/1917 LA 94 Usual Residence of Dece or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 ☐ No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b once. Funeral 20879 USA 7512 Elioak Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Nidowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Janie Smith Edgar Emerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2009 Burnside Dr., Frederick, MD 21702 Edward Johnson/grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 01/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Glade Cemetery Walkersville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prevolution/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine rt any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death cerlificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ater Month Dav Year Pregnant at time of death ed by the a detached 9 | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗌 No 3 🗌 Probably 4 🌂 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 \(\sum \) Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 X Natural 5 Pending NA Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [

State

Registrar DHMH 17 Rev 06-2011

29b. Signature and title of certif

30. Name and address of person

Registrar's Signature

740860

29d. Date signed (Month, Day, Year)

1-18-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per med cert 6924 2/9/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2SAM Day Physician/ Month Year Mackereth Richard 20 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIty Baltimore The Johns Hopkins Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 219-44-4776
Usual Residence of Decedent 1 🗶 M 2 🗆 F 66 April 1 1945 Maryland 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 🛣 Yes 2 □ No Maryland Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral or items 23a 967 Noland Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates.1966-68 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify 'natural", 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) 12 Track Inspector Railroad of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clifton Hoe Mackereth Evelyn Gertrude Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 Brenda Mackereth - Wife 967 Noland Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 24. 1 X Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cedar Lawn Mem. Park Hagerstown, Maryland Signature of Funeral Service Lie 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final. -Physician/ Renal cell Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physiciar Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ō Pregnant at time of death Unknown Month Day Year Yes 2 No ed by the a g Unknown s been signed by the should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Physician: The certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28h Time of 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year R. MD es-00(January 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 Michael R. Grunwald North Wolfe Street Baltimore. MO 600

State

Registrar

31. Date filed (Month, Day, Year)

JAN 23

32. Redstrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Q** 1 JUN MIAD 8:15 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SPRING MONTGOMERY LAYHILL CENTER SILVER GENESIS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
August 17, 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Funeral Hours 91 China Director 214-33-4663 ,192d Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Gaitherburg Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral United States 20877 113 Goucher Terrace Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Asian 3 X Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Coilege (1-4 or 5+) Elementary/Seconday (0-12) Accounting Accountant should be filed with and Mental Hygien 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Xu Ointang Miao permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9956 Lochmoore Lane, Vienna, VA 22181 Chuangi Miao (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Jan, 21, 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Mem. Pk. 21. Signature of Faneral Service 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter the d complications that of Approximate Interval Between Onset and Death Imn ediate C use (Final dise ondition CANCER IVER Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 X No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Watural 5 Pending 2 🗀 No 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29d. Date signed (Month, Day, Year)

State Registrar SAADIA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSAIN

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00064208

BELPRE ROAD, SILVER SPRING MD 20906

State of Maryland / Department of Health and Mental Hygiene 2012

State AMEND#10cper:INF, 1/27/12; BW, McCo
Registrament D, 1/27/12; BW, McCo
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Day} 20Ĭ2 January 5:38pm M Gary R. McKay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD **Examiner** 11023 Doxberry Circle Woodstock timore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 04/28/1938 1 😿 M 2 🗆 F Director 73 Pennsylvania 297-32-6447 Usual Residence of Decedent or 28a-f show notified at 10b. Count 10a. State 10c. City, Town or Location 10d Inside City Limits Director **HOWARD** 1 Yes 2 K No Maryland | Baltimore Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 11023 Doxberry Circle 21163 United States should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 □ No 1956 Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 1976 "natural" 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Senior Navy Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Methel Thatcher Rex McKay 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7013 Meandering Stream Way, Fulton, MD 20759 Brenda McKay Eshelman Important: If item any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Metropolitan Crematory 1/17/2012 Alexandria, Virginia

22 Name and Address of Facility DeVol Funeral Home
10 East Deer Park Drive
Caithersburg, MD 20877 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Mucol 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Year Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4x Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifice corputed filled in by the funeral director, for the fune 25. Was case referred to medica of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence 6 \(\text{Other} \) Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 🛭 Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) D50338 January 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Pio Lontok Poblete 11055 Little Patuxent Parkway, Suite 103, Columbia, MD 21044 31. Date filed (Month, Day, Year)

JAN 2 0 2012 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

		Pleas	se Type or	Print in	Black In	delible Ink	. Ensi	ure A	II Copies	s Are I	_egible.	,
		For State Registrar	State	of Marylar		rtment of H tificate of D		and N		giene Reg. No. 2	2012	02954
Physicia	ın/	1. Decedent's Name (First, Middle, John Francis	· ·	ridge,	ТТТ				2. Date of Dea Month Januar	ath	2012	3. Time of Death
Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or	Location o	of Death	Januar	_	ounty of Deat	12:30 a ^M
		Shady Grove Ad		Hospital	1	Rockv:					ntgome	
Funeral Director		1	3. Sex 1 Å M 2 □ F	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under : Hours	24 Hrs. Min.	8. Date of Birti (Month, Day			thplace (State or Foreign untry)
		216-64-4889 Usual Residence of Decedent	1 ≅ M 2 ⊔ F	58	Yrs.				Feb. 4,	1953	Wash	nington, DC
Maryland 28a-f sho otified at	Director	MD 10b. County Mont	gomery		y, Town or Loca Gaither							10d. Inside City Limits 1 ☐ Yes 2 ※ No
th the		10e. Street and Number	1 4 .			10f. Zip Code				10g. Citize	n of What Co	untry?
ath wit	Funeral	879 Clopper F		edent Ever in U.S	S 13 W	20878 as Decedent of His		sin2 (Sne	cify Yes or No-	USA	, Race - Ame	vices Indias
rs after de ıral", or ite Examine	by	Never Married 2 Married 3 Widowed 4 Divorced		orces? 2* No ve	lf.	Yes, specify Cubar	n, Mexican	, Puerto	Rican, etc.)		Black, White Becify: Whi	e. etc.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Department of Heath and Mentall Hygiene. and uncertaint life m Z'is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			(Give ki life, DO	ent's Usual Occupa nd of work done di NOT use retired)		of worki	ng		of Business/	
led with Hygie other ent, the	Be (17. Father's Name (First, Middle, La			Cour	ler	18. Mothe	er's Name	e (First, Middle,		BC New	<u>s</u>
ld be fi Mental a rked atic ev	입	John F. McCamb	ridge, J	r.			Jean					
shoul n and 7 is m raum		19a. Informant's Name/Relationship John Francis Mc		- / C		Address (Street a				-		
and 2 Healt! tem 2		20a. Method of Disposition	Campring		Place of Dispos	Arizona	Circ				D 2081 ition - City or	
age 1 ent of nt: If i		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		n State	emetery, crema	atory or other place an Cremat			^{Date} 19, 2012		ndria,	
ermit. F epartm nporta ny inju		21 ghz r of Funeral Service Lic		1		Name and Address						VII
85 E W 9	- 1	PARILLY!	OVYC		1500	J Univers	sity]	Blvd	. W., S	ilver	Sprin	g. MD 20901
		23a. Part 1. Enter the disease for c shock, or heart failure. List on Immediate Cause (Final	ly one cause on ea	ach line.								Approximate Interval Between Onset and Death
hysician/ Medical		disease or condition resulting in death)		racere (or as a consequ		leed wit	n bi	rair	1 herni	attor	7	
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physicial the buri	Physician/Medical		d. <u>5</u> c	P519								
certing ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	incy	Ectopic pregnancy				236	d. Date of del	ivery
the attrophed for	ıysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Preg 9 Unk	gnant at time of o	death 5	Other (specify)					Month	Day Year
that tr ned by e deta		Part II. Other significant condition	- 1:		- 1				23e. Did to	bacco use	contribute to	the cause of death?
equires sen sig ould b	ted	cardiomyopathy	with e	ejection	traction	on ot a	0-25	0/0	1 🗆 ነ	res 2 🔀	No 3 🗆 Pi	robably 4 🗆 Unknown
has be	Completed by								24a. Was a autop perfor	sy	24b. Were aut prior to death?	topsy findings available completion of cause of
ificate or, pag	မ လ	25. Was case referred to medical				26 Pla	ce of Deat	h (Chack	1 🗌 Yes			2 🗆 No
lysicia is cert direct	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗍	ER/Outpatient	Other	r.		me 5 Aesid	ence 6 \square	Other (Spec	ify)
ing Pri		27. Manner of Death 1 → Natural 5 → Pending	28a. Date (Mon	of injury oth, Day, Year)	28b. Time of injury	28c, Injury work?	at	12	28d. Describe he			
Attend r death ctor: /	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - At ho	me, farm, stree		∕es 2□	-	28f. Location (S	treet and N	lumber or Rui	ral Route Number,
intal or y urs after ral Dire			buildi	ing, etc. (Specify	*)				City or Town	n, State)		
To the nograph of Attending Proysician: The law requires that the death definitions be ex- within 24 hours affected death. To the Funeral Directors Affer this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buna	Medical	(Check 2 Medical Exa	Physician: To the base aminer: On the base lurse Practitioner	sis of examination	and/or investig	gation, in my opinior	n, death oc	curred at	the time, date ar	nd place, ar	nd due to the d	cause(s) and manner stated.
3 a salar		29b. Signature and title of certifier Secure	ell			29c. License 7\32			1	29d. Date s	igned (Month	o, Day, Year)
		30. Name and address of person who USha Kiran Yen	igalle, 9	901 Med	lical Ci	enter Dr	ive,	rock	wille, 1	May	lord.	20550
Stat Registra	.e	31. Date filed (Month, Day, Year) JAN 2 0 20	12 2	Registrar's Signat	fure fact	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Rex William Mills 2012 January Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1806 Woodrail Drive Millersville Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Months Min. Director 202-30-6721 73 1**X** M 2 □ F Yrs 1938 Pennsylvania Apr. 27, Usual Residence of Decedent 28a-f show items 23a or 28a-f shoner must be notified at 0a, State 10b. County 10c. City. Town or Location Director 1 Yes 2 No Millersville Anne Arundel MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 1806 Woodrail Drive 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1X Yes 2 No Army
If Yes, Give ō 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) NCR Senior Accounts Manager 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Raymond Mills Florence Rex traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sharment of Health a tant: If item 27 is 1806 Woodrail Dr., Millersville, MD 21108 Jean A. Mills/wife other. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Burial 2 XCremation 3 Removal from State Metro Crematory Department of Important: If any injury or once. injury or 1-18-2012 Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ancreat to a disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No Yes 2 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) To Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

CH15H1 State

M. Naovi Horiba 22 S. Circene St S9D Baltinore
31. Date filed (Month, Day, Year) 2004 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McNair Month James 8:17 PM 01/15/ 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) **Director** 409-17-2243 1 X M 2 - F 50 Yrs. 07/16/1961 TENNESSEE Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be r Funeral USA 2048 FOREST DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) MECHANIC MACHINERY REPAIR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. JAMES HENERY MCNAIR SR. MARGARETTE LOUISE JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2048 FOREST DRIVE ANNAPOLIS, MARYLAND 21401 VERONICA MCNAIR/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State BESTGATE MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 01/21/2012 ANNAPOLIS, MARYLAND TRIBUTES BY FELLOWS MATION & FUNERAL CARE P.A LIS, MARYLAND 21401 22 Name and Address of Facility I. HELFENBEIN & NEW 14 BESTGATE ROAD 21. Signature of Funeral Service Lice Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. Est only one cause on each line. Approximate Interval Betweer mediate Cause (Final Onset and Death Physician/ Pulmonar. one morth disease or condition resulting in death) Medical Examiner vedus Sequentially list conditions, Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes mallitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Sleep Apnea 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has page 2 within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature

Stephen Killian

JAN 1 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3169

Braverton St #201; Edgewater MD

29d. Date signed (Month, Day, Year)

January

16 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month III Mattingly Charles Jenkins 2012 6:15 p.m M 16, Medical <u>January</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Mary's Hospital Leonardtown Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days (Month, Day, Year) 08/07/1943 Hours Min. Director 68 Washington, DC 216-40-7035 Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 X No Maryland Mary's Hollywood St. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral United States 43121 Joy Lane 20636 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hydiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. "natural", 3 X Widowed 4 ☐ Divorced White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Fire Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Jenkins Mattingly, Jr. Mary Loretta Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Kimberly Guy/Daughter 43115 Joy Lane, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 01/20/2012 Hollywood, Maryland gnay of Maral Service Ligensee Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22055 Hollywood Road, Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ denocaranoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner oloma MY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed -ancomia that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death signed by the a Id be detached for 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Drewmom a 2 🗹 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 After this certificate has funeral director, page 2 s 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural s after dec. 5 Pending ☐ Accident ☐ Suicide Investigation Could not be the Funeral Directory filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check only one) 29b. Signature and title of certifil 29d. Date signed (Month, Day, Year) 1)060473 mpleted cause of death (Item 23a) (Type, Print) 10 pme 20650

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

IN Chur Baltimore, I

Division of Vital Records, P.O. Box 68760

conord town.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Robina Bryden McGregor Medical 4a. Facility Name (if not institution, give street and number) Examiner St. Mary's Nursing Center 5. Social Security Number Age (In yrs. last birthday) Funeral 1 □ M 2 💢 F 89 Director 577-48-4976 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director MD St. Mary's 10e. Street and Numbe Funeral 25336 McIntosh Road . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", o ; the Medical Exam 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) should be filed within 72; and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) other traumatic event, Be 17. Father's Name (First, Middle, Last) ည James Neilson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) William McGregor 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Margafet H. Hicks M01631 Immediate Cause (Final Physician/ Stoop disease or condition resulting in death) Medical Examiner dequartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 9 Unknown 9 Unknown P.O. ò has beer signed e 2 should be det þ Records, Completed Vital Was case referred to medical Be Hospital 2 V No 1 Yes မ Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: eral Director: After a filled in by the funera To the Hospital or Attending Natural 5 Pending injury 2 Accident 3 Suicide Investigation Could not be 4 Homicide determined Medical 29a. Certifier

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Year Month Day 9. January 4b. City, Town, or Location of Death 4c. County of Death Mary's Leonardtown 8. Date of Birth
February 11,1922 Country
Scotland If Under 24 Hrs 8. Date of Birth Days Months Hours 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Hollywood 10f. Zip Code 10g. Citizen of What Country? 20636 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No Specify. Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Dress Shop Owner Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) Margaret Neilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollywood, Maryland 20636 25350 McIntosh Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/23/12 Brinsfield-Echols Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 - Residence 6 - Other (Specify) 28c. Injury at 28d. Describe how injury occurred work? 2 🗀 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARTIN Physician/ Month COBERT 2017 00: 29 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDIUM CONTER BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 1 XM 2 □ F Hours 578-50-1069 **Director** 73 May Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 X Yes 2 □ No Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2807 Birkle Lane 20747 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** "natural" 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) and Mental Hygiene. is marked other tha Contract Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Menta fitem 27 is marked r other traumatic e Unknown Emma Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Martin/Wife <u> 2807 Birkle Lane Forestville MD 20747</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 4 Donation 5 Other (Spec 1-20-2012 Suitland, MD 21. Signature of Funeral Service Lin 22. Name and Address of Facility Pope Funeral Homes, P.A. 1010108 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ANAPLASTIC LARGE CELL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examir burial-transi Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months? Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide Investigation M 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 1/15/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ("HRISTOPHER KOLTZ 22 S. GREENE St. BATIMONE, MD 21201 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. ^{Day} 2012 KATHERINE С. MILLER 7:40 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16646 VIRGINIA AVENUE WILLIAMSPORT WASHINGTON Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs, last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Director 234-01-7874 93 3/29/1918 WEST VIRGINIA Usual Residence of Decedent 23a or 28a-f show I and 2 should be filed within 72 hours after death when the wift Hogiene.
If Health and Mental Hygiene.
If Health and Mental Hygiene.
When traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD WASHINGTON WILLIAMSPORT 1 🗆 Yes 2 💆 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 16646 VIRGINIA AVENUE 21795 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) NELLIE SUSAN CUSHWA CHARLES DAVID CATROW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2150 WHITACRE ROAD, CROSS JUNCTION, VA 22625 SHARON SHANK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or or ᇹ JANUARY 26, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TUSCARORA CEMETERY MARTINSBURG, WV 2012 . Signature of Funeral Service License 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
2 years Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 W No
9 Unknown Day Month Year Pregnant at time of death 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed death? 1 Yes 2 No 1 🗆 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie DO05/282 WILL 14MSPORT, MD 21795

State Registrar

DHMH 17 Rev 7/2009

SAMUEL RADIM. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Pring & WILL IAM)

32. Pegistrar's Signature

Date filed (Month, Day, Year)

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ NEALE 1126 PM *20*(2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death HOSPITAL BETHESDA MONTGOMKRY If Under 1 Year If Under 24 Hrs. 6 Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 579-48-2505 **Director** 1 M 2 X F Washington, DC 82 Dec. 31, 1929 Usual Residence of Decede 28a-f show aţ 10a, State 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified MD 1 Yes 2X No Montgomery Silver Spring ò 10e. Street and Number 10f, Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 13004 Middlevale Lane 20906 USA items ı "natural", or item edical Examiner ⊓ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Specify: White 1 Yes 2 No Specify 3XXWidowed 4 □ Divorced Completed Year or Dates r than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Administrative Assistant Episcopal Church other 27 is marked othe traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Robert I. Ammann Pauline Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Brian Neale/Son 1075 Space Park Way, #246, Mountain View, CA 94043 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. I ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, uneral Service Li ignature of Gates MD 20901 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause terval Between RESPIRITORY Immediate Cause (Final FAILWRE Priset and Peat Physician disease or condition Medical resulting in death) Examiner PNBUMON + A rewriting Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying seudomonies wing hesches Cause (Disease or injury and that initiated events resulting in death) Last as the burialattending physician Physician/Medical law requires that the death certificate be 68760 IE FEMALE: nse yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No
9 Unknown Month Day sign d by the o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CHRONIC OBSTRUCTIVE LUNG DISOTSE, RHEUMTOIN Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes been : HRTHRITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' Yes 2 No Vita . Was case referred to medical 26. Place of Death (Check only one) examiner? 10 1 Yes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director, After this ampletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifi 036252 of person who combleted cause of death (Item 23a) (Type, Print)
7. KHRIYA, MD, 10605 CONCORDS7. #500 KENSINGTON MD 20895

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Christine Nagao January 16, 2012Рм 4:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 7. Age (In vrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) Director 218-76-5679 1 □ M 2 □**X**F 1959|Washington, DC July 18, Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Derrydown Lane 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Clerk of Court Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H 7 is marked ot Braden Lee Work Lillian Marie Culliton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Nagao/ Husband 505 Derrydown Lane Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 1/19/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition Medical resulting in death) **Examiner** Aspiration Pnuemonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Month Pregnant at time of death Day Year 1 Yes 2 X 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiac Arrest 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifics completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No Other: မ 1 X Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 — Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66249 1/17/2012

Registrar

DHMH 17 Rev 06-201:

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Holy Cross Hospital, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Jonathan Duran, M.D</u>

JAN 1 9 2012

			Please	e Type or Pri	int in	Black Ir	ndelible li	nk. Ensure	All Copie	s Ar	e Legible.	
		For		State of M	larylan	id / Depa	artment of	Health and	Mental Hy	/giene	9	00000
	_	 State Registrar 				Cer	tificate of	Death		Reg. N	2012	02963
Physicia	./	1. Decedent's Nam		,				_	2. Date of De		Ou Voor	3. Time of Death
Medic			roll An						Januar		, 2012	11:55 p. ^M
Examine	er			e street and number)				or Location of Dea	ath	40	c. County of Deat	
Eumovol		Asbury 5. Social Security N		Health Ca		enter ast birthday)	Solom If Under 1 Yea		s. 8. Date of Bi	rth	Calvert	thplace (State or Foreign
Funeral Director		278-14-5		1 □ M 2 🔀 F		94 Yrs.	Months Day			ay, Year)	917	ohio
M		Usual Residence of	Decedent						ind) 2		,,,,	
yland f shc ed at	to	10a. State	10b. County			ty, Town or Location						10d. Inside City Limits 1 ☐ Yes 2 No
e Mar r 28a	Şire	MD 10e. Street and Nur	Calver		'	Solomons						
ith th	la l			1 A	000		10f. Zip Code				itizen of What Co	,
ath w	Funeral Director	11. Marital Status	sbury C1	rcle Apt.	S. 113. V	2068		Specify Yes or No		ted Sta		
or it			ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐				Hispanic Origin? (ban, Mexican, Pue	rto Rican, etc.)		Black, White	
ural", ural",	ted	3X Widowed	4 Divorced	If Yes, Give Year or Dates.	•	1	☐ Yes 2 🔀 N	No Specify:			Specify: Wh	ite
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thin 7 ene. than	Š	Elementary/Sec	onday (0-12)	College (1-4 or	5+)		O NOT use retire			,,		
ed wi Hygie other	Be	17. Father's Name (First, Middle, Lasti	4		j Bua	get Ana		ame (First, Middle		Govern	nment
be fil ental 'ked ' ic eve	၉	,	. Underw					Anne C		, waler	Guriame)	
nould and M s mar	1	19a. Informant's Na				19b. Mailin	a Address (Stree	et and Number or F		er. Citv o	r Town, State, Zir	Code)
d 2 shalth a alth a 127 is		Wayne Pu	tnam/Exe	cutor				Drive, (
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	position	Removal from State	20b. P	lace of Dispo	sition (Name of		Date		ocation - City or	
Page ment ant: 1 ury o			5 Other (Spec		Imm	aculat Marv C	natory or other po e Heart emetery	01/	/19/2012	Lex	ington P	ark. MD
ermit. epart nport ny inj nce.	ĺ	21. Siff (Cont 50	regal Server Lice	Sichs			. Name and Add		rinsfield			
		Margar			0163			lywood Ro	oad, Leon	nard		
		shock, or hea	rt failure. List only	nplications that cause one cause on each line	d the deat e.	h. Do not ente	r the mode of dy	ring, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a. END.	STAC	SE CON	CESTIVE	HPART	FAILV	RF		Onset and Death
Examiner		resulting in death)	•	Due to (or as	a consequ	uence of):						1 22.
	Į.	Sequentially list co	enditions,	b. Due to (or as			CARD	10 VASCUL	AC DIO	1-79-	10	f I=ARG
ted I Insit	Examiner	cause. Enter Unde Cause (Disease or	rlying iinjury	,								
e executed vian and urial-transit		that initiated event resulting in death)		C. Due to (or as	a consequ	uence of):					-	
	ical		•	d								
tifical ng ph as th	Physician/Medic	IF FEMALE:					 			T		
th cer ttendi	ian/	23b. Was decedent in the past 12		23c. If yes, outcome 1 Live Birth	2 Feta	al death 3	Ectopic pregna	ncy			23d. Date of del	
e dea the a	ysic	1 ☐ Yes 2 \$ 9 ☐ Unknown	₹ No	4 Pregnant a 9 Unknown	at time of c	death 5 ∟	Other (specify)				Month	Day Year
at the	된			contributing to death b	out not res	ulting in the u	nderlying cause	given in Part I.	23e. Did 1	obacco	use contribute to	the cause of death?
signe d be	d by								1 🗆	Yes 2	<u>□</u> -No 3 □ Pi	robably 4 Unknown
requ been shoul	Completed								24a. Was	an	24b. Were au	topsy findings available
e has	崩								auto perf	psy ormed?	prior to death?	completion of cause of
an: The tifficat cor, per	Be C	25. Was case referre	ed to medical				26	Place of Death (Ch		2 XX	lo 1 L Yes	2 L No
ysicia is cer direct	2 P	examiner?	No No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatien		ther:	Home 5 Resi	dence (6 ☐ Other (Spec	ifv)
ng Ph ter thi		27. Manner of Deatl		28a. Date of inju	iry	28b. Time of injury	28c. Inj		28d. Describe			
eath. or: Af the fu	fica	1 🗶 Natural 2 🗌 Accident 3 🔲 Suicide	5 ☐ Pending Investigation 6 ☐ Could not	n	,,,	,,	M 1	Yes 2 No				
or Att	Certificate:	4 Homicide	determined				et, factory, office	e	28f. Location (City or Tox			ral Route Number,
pital ours a sral D		00 0 00 4	V O	· · · · · · · · · · · ·								
24 hc 24 hc Fun	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e	xamination	and/or invest	igation, in my opi	nion, death occurred	d at the time, date:	and place	e, and due to the o	cause(s) and manner stated
o the vithin o the complex com		only one) 3 29b. Signature and		rse Practioner: To the	best of my	/ Knowleage, a		tne time, date and p ise number	place, and due to tr		s) and manner as ate signed (Month	
->-0		1	2/14-	T/ous l			D	26358			_	16,2012
	ŀ	30. Name and oddre	ess of person who	completed cause of d	leath (Item	23a) (Type, P		~ - 3 1 0		7/-	700/00/	(8,0-01)
s) pme		Dr	hn Waire	1 M D 11	O Hos	enital	Pond D	rince Fr	ederick,	MD	20678	
State)	31. Date filed (Mont	h, Day, Year)	2012 32. Projector	ar's Signat	ture	,					
Registra	r		ANU T (CUIC ABOUN	m.	B. 4	arkel					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 11 20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AAMC thnapolis 6. Sex 1 **X**M 2 □ F Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Hours 0272774930 Washington, DC **Director** 579-38-2647 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-6-100c.
any injury or other traumatic event, the Marked 1 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 United States 3660 North Carolina Avenue Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married by 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced 1950-52 Specify White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Business Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine DiBlasi Joseph Origlio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3660 North Carolina Avenue, Edgewater, Maryland 21037 LaVerne R. Origlio/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01/22/2012 Edgewater, Maryland 4 Donation Kalas Crematory 21. Signature of 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1 Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -XACE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-t by Physician/Medical Division of Vital Records, P.O. Box 68760 as signed by the attending I IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been sic Completed Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 autopsy certificate had lirector, page 2 perform 1 Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) ٥ 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient R/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ZUZ 1141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 lle 21401 State Dark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G926/4/16/2012 Jh State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Denise Outterbridge Month 2012 11:45 pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ft Washington Hospital P.G. Ft Washington 5. Social Security Number 578-74-2321If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) (Month, Day, 1 □ M 2 😾 F ^{Year)} 953 58 Director Usual Residence of Decedent show 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Funeral Director MD Prince George' Ft Washington 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 Kimberly Wood CT 20744 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: SpecifBlack 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Substance Abuse Counselor (Specify only highest grade completed) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked မ Alfonzo Outterbridge un-avail Helen 9a Hormant's Name/Relationship (Type, Print)

Daug DOILLER Outterbridge-Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
302 Kimberly Wood Ct Ft Wash, MD 20744 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl 1 Durial 2 Cremation 3 Removal from State 1/12/12 Silver Hill, MD Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service 22. Name and Address of Facility McLaughlin Funeral Home 2518 Pennsylvania Ave SE Wash DC 20020 Licensee 23a. P. 1. Enter Sase, or complications and k, or hert failure. List only one cause ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death HEART Discuse I modiate C se (Final disease or condition Anterio schentie Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?

1 Yes 2 Who

9 Unknown Month Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Non Ensulin Depelendent Distretos Division of Vital Records, 1 XYes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Within 2 To the P 29b. Signature and title of certifier 735206 Willen T. Varrein 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingson Road Fat WARHINGTon, many/md William T TANNER MY

State

Registrar

1 9 2012

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SPAD 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** JuliaManor lashington Havere otor 8. Date of Birth (Month, Day, Year) July 6, 1921 Birthplace (State or Foreign Country) **Funeral** Months Hours 1**X**M 2□ F Director Pennsylvania 169-14-7964 90 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20014 Rosebank Way, #201 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give marked other than "natural", 3 Widowed 4 Divorced Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manufacturing Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Puskar Catherine Puskar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m Department of Health ar Important: If item 27 is any injury or other trau Mrs. Joanne Parker / Daughter 11823 Partridge Trail, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory | 1/24/2012 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ice Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscler disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical portension Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the t IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No signed by the a Id be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by Heart 1 Yes 2 No 3 Probably 4 Unknown Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an AccideNT After this certificate has completely filled in by the funeral director, page 2 autopsy performe 2 🗌 No 1 🗌 Yes Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🛱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 333 Mill Street, Haberstown, MD 21740 Naclen

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Day Month Norman Pearl 11:30A 2012 <u>January</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veteran Home St. Mary's Charlotte Hall Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M 2 D F **Funeral** Days Months Hours Min. 09/10/192 Director 019-14-0808 Massachusetts 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 🗆 Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 328 Savannah Road 21221 USA r than "natural", or items the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: White 3 Widowed 4 Divorced "natural", Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. 5+College (1-4 or 5+) Elementary/Seconday (0-12) Teaching Humanities Professor Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leo Pearl Mary Sugarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan D. Pearl / Son 212 Pelagie Lane, PO BOX 1564, Solomons, MD 20688 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD Veteran Cemetery 01/25/2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard ailure. List only one cause on each line.

Immediate Cause (Final disease or conditions) 30195 Three Notch Road, Charlotte Hall. MD 20622 Approximate Onset and Death CARDIAC ARRHYTHMIA Physician/ disease or condition Medical resulting in death) **Examiner** PERTENSION SSENTIA Esquentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 1 Yes 2 G 9 Unknown detached After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE ZHEIMERS 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 1 Yes 2 A No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 24 hours after death Funeral Director: A Investigation filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

8+ lence

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO

MD

KODALI 29449 Charlotte Hall Road, Charlotte Hall, MD 31. Date filed (Month, Day, Year)

D0067788

29d. Date signed (Month, Day, Year)

1.17.2012

State Registrar

29b. Signature and title of certifier

Calle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Aloysious Parker Year 01/11/2012 Medical 5:45 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home St. Mary's Charlotte Hall **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Min. Hours 579-40-0314 Country)
Marvland Director 03/04/1926 85 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No St. Mary's Charlotte Hall 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Appred Forces? 1 ♣ Yes 2 ☐ No 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates "natural", Completed 3 Midowed 4 □ Divorced SpecifyAfrican America other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumate. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Security Guard Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Plater Julia Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivan Julian / Son 264 North Sixth Street, Brooklyn, New York 11211 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Arlington NationalCem 02/16/2012 Arlington, Virginia Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cellular disease or condition Hepato Carcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transi signed by the attending physician and deetached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Day Year Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Diabetes Type 2, Hypertension, Conjective heart 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown duiture, Peripheral arterial disease. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after deatn.

To the Funeral Director. After this certificate is completed filled in by the funeral director, pag performed? Yes 2 N 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

3+1VA State

29a. Certifier

(Check

29b. Signature and title of certifier

Thubentos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santha MD

D0064324

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 1/12/2012

, 100 Hospital Rd, Prince Frederick, mo, 20678

City or Town, State)

MD

31. Date filed (Month, Day, Year) 32. Fegistrar's Signature

building, etc. (Specify,

Registrar

			Plea	ise Type or								-	gible.	
			For State	State of	of Maryla					and M	lental Hyg	iene	O 1 (2 22/10
			Registrar 1. Decedent's Name (First, Middle	(ast)		Ce	rtificate	ot D	eatn		2. Date of Deat	eg. No. 🧷	416	2 0400
	Physicia			n Philli	os						January		1 1 2 ar	3. Time of Death 10:37p M
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			St. Mary's Ho	spital					dtov	vn	St. Mar			y's
	Funeral Director		5. Social Security Number 245–66–8043	6. Sex 1 ☐ M 2 🙀 F	7. Age (In yrs	last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 01/17/	Year)	9. Birl	thplace (State or Foreign untry) rth Carolina
			Usual Residence of Decedent		00	, 110.					01/1//	1944	No	rth Carolina
	land f shov	tor	10a. State 10b. County		10c. 0	City, Town or Lo	cation							10d. Inside City Limits
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show the other than "natural", or items 23a or 28a-f show it event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, L	ast)					18. Moth	er's Name	(First, Middle, N	laiden Surnam	ie)	
yla	ould be fil nd Mental marked matic ev	으	Willie James	Lewis					Sac	die	Mae St	anton		
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	and and the Healt tem 2		20a. Method of Disposition	Daugnte		Place of Dispo			Tue			20c. Location		
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Baltimore,	in injury		21. Si Jayof Fuperal Service	consult /	cla		2. Name and		_		insfiel			
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DIVISION	I or At after a Direc	Cer	4 Homicide determi	ned 28e. Place	of Injury - At I ng, etc. (Spec	nome, farm, str ify)	eet, factory, o	office		1	28f. Location (Str City or Town		er or Rur	al Route Number,
נ	ospita hours ineral d fillec	Medical	29a. Certifier Certifying	Physician: To the b	est of my kno	wledge, death	occured at the	e time, c	date and	place, and	d due to the caus	e(s) and manr	ner as sta	ted.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 25 hours after death, there this certificate has been signed by the attending physici ormpleted filled in by the funeral director, page 2 should be detached for use as the but	Mec	only one) 3 L Certifying	xaminer: On the bas Nurse Practioner:	is of examinati To the best of i	on and/or inves my knowledge,	tigation, in my death occurre	opinion, d at the t	, death oo time, date	ccurred at and place	the time, date and e, and due to the	d place, and du cause(s) and m	e to the canner as	cause(s) and manner stated. stated.
	Neitl Con 10 I		29b. Signature and title of certifier	7 -			29c. L	icense r	number	201	21	d. Date signe	d (Month	Day, Year)
							I D	00-	TU	200	0 0	WOUR	4.	41, 2012
2	Deme		30. Name and address of person v	The completed cause	e or death (Ite	m 23a) (Type, F	O Pa	Int	Loc	KDV.	+ RM	1 ADM	ava.	Ann MD
	Stat	е	31. Date filed (Month, Day, Year)	2012 32/8	egistrar's Sign	ature	. 4 1	. ,	300			V U- V -	71	7050-00

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State of Maryland / Department of Health and Mental Hygiene

		1	For State Of Wal		tificate of Death		Reg. No. O	02070
	Physicia	- /	1. Decedent's Name (First, Middle, Last) Barbara Porter			2. Date of Dea	ry Day, 201	J. Tillie of Death
	Medic Examin	al er	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring	bandar	4c. County of Dear	th
	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	in yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, Day	(, Year) Co	thplace (State or Foreign untry)
	laryland 3a-f show iffied at	유미		Oc. City, Town or Loc Silver S				10d. Inside City Limits 1 Yes 2 □ No
	with the Ns 23a or 24		10e. Street and Number 12801 Old Columbia Pike	# 130	10f. Zip Code 20904		10g. Citizen of What Co	ountry?
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of Hispanic Origin? (Spr Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	hin 72 hou ne. than "nat te Medica	omplet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give F	lent's Usual Occupation kind of work done during most of work O NOT use retired) Teller	ing	16b. Kind of Business Private	/Industry
and 2	be filed wil ental Hygie ked other ic event, the	a) h	12th I 17. Father's Name (First, Middle, Last) Edward T Nelson	Dame			Maiden Surname) lure	
Maryland	d 2 should alth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Print) Ronald Porter - Son	19b. Mailir 1280	ng Address (Street and Number or Rur. 1 Old Columbia	al Route Number Pike	r, City or Town, State, Z # 130 Sil	p Cod Md 20904 ver Spring
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 🏝 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Heaven	2012 l	20c. Location - City of Silver Sp	ring Md
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	ificate be executed Medical Examiner as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute b. Due to (or as a cut) Chron C. Due to (or as a cut)	onia consequence of): Renal F consequence of): ic Obstr				Approximate Interval Between Onset and Death
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ls, P.O.	requires that the death been signed by the atte should be detached for	ed by Ph	Part II. Other significant conditions contributing to death but	not resulting in the u	ınderlying cause given in Part I.		obacco use contribute t Yes 2 🏻 No 3 🗀 I	o the cause of death? Probably 4 Unknown
Record	nysician: The law requisic certificate has bee I director, page 2 sho	Completed				24a. Was auto perfo 1 \square Yes	psy prior to prior to death?	utopsy findings available completion of cause of es 2 \(\square\) No
ta	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatier		26. Place of Death (Chec			
of V	□ ÷ □	te: To	27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatien 28b. Time of Year) injury	nt 3 ☐ DOA		dence 6 Other (Spenow injury occurred	icity)
Division of Vital Records,	il or Attending Ph s after death. I Director: After thi d in by the funeral	Certificate:	2 Accident Investigation	y - At home, farm, str	M 1 Yes 2 No	28f. Location (\$ City or Tov	Street and Number or R vn, State)	ural Route Number,
Ω	Hospita 4 hours Funeral tely fille	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of many one) 3 Certifying Physician: To the basis of examiner: On the basis of examiner: To the	amination and/or inves	stigation, in my opinion, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated.
	To the I within 2 To the I comple	2	29b. Signature and title of certifier		29c. License number D65953		29d. Date signed (Mon	th, Day, Year)
n	3		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, I	^{Print)} 8720 Georgi	a Ave	Silver S	Spring Md 20910
1	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	s Signature	,			

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		For		State	of M	arylan				lealth and	Mental Hy	/gien	е			
		State Registrar					Ce	rtificate	of E	Death		Reg. N	10.20	2	0297	
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Funeral Director		5. Social Security N 150-22-3		6. Sex 1 ☑ M 2 ☐ F	_	e (In yrs. Ia 80	ast birthday) Yrs.	If Under 1 Months D	Year Days	If Under 24 Hrs Hours Min.		rth ay, Year	31	Birthpla Country	ce (State or Fore	ign
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fter c	र्	11. Marital Status 1 Never Mari			orces?	No		Was Decedent If Yes, specify 1 ☐ Yes 2 2 2		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, Wh Specify.Whi	nite, etc		
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With To With		29b. Signature and	title of certifier		1	71	ND		icense	number 457			ate signed (Mor			
'		30. Name and addr	ess of person w		use of de	eath (Item	23a) (Type, F ationa	Print)		#211, S	ilver S			_		
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any	-	10a. State	10b. County			10c. C	ity, Town o	r Location								Inside City Limits
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ō	Maryland		omer	у		Gaith	ersbur					40= Ci	tizen of What C		Yes 2 X No
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with th	le l	21823 Gos 11. Marital Status		1:	2. Was Dece	dent Ever in	U.S.	13. Was Dece	dent of H	ispanic Origi	n? (Spec	cify Yes or I		14. Race - An White, etc		ndian, Black,
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Baltimore, permit. Pages 1 a Department of the Important: If its injury or other timing in the content of the c		1 X Burial 2	Crematio		Removal fro	m State	cremato	ry or other pla	ce)		22/02	2/2011			M	arvland
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Physician /Medical		failure. List or	nly one cause	on each	line.											tween Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exervithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial.		IF FEMALE: 23b. Was decedent			23c. If yes, o		regnancy 2	Fetal dea	ith 3	Ectopic	pregnano		23	3d. Date of deli Month	very Day	Year
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Hospita 4 hours Funera ely fille		4 Homicide 29a. Certifier (Check only	Certifying	Physician	: To the bes	Surgi t of my know	ledge, dea	th occurred at	the time,	date and pla	ce, and d	ue to the ca	ause(s) a	e,MD. and manner as	stated.	
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	edical	one) 2 🗸	7	aminer: O	n the basis o	of examination	n and/or in	vestigation, in	my opinio	on, death occ	curred at I	the time, da	ate and p	lace, and due t	o the cau	
	ž	29b. Signature and	d title of certif	ier / ^						nse number				nuary 30, 2		ay, Year)
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		Carol Allan	i, MD A	ssistant	Medical I	Examiner	900 V	V. Baltimor	e Stree	t, Baltimo	re, MD	21223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death January 2012 Year Gerald Lee Ruehl 1608 Рм 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Calvert Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Months /29/1954 Ohio 57 216-64-1885 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 U. S. A. 8404 Croom Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 X No Black, White, etc 1 Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Counselor, Private Treatment Elementary/Seconday (0-12) College (1-4 or 5+) Substance Abuse Centers 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Rome Rueh1 Dorothy Charles Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Yoakum Parkway, Alexandria, VA Charles A. Ruehl/Father 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Atlantic Crematory 1/18/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Vice Ce 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Securitially let on ultimate if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last as a consequence of): IF FEMA 23b. Was in th 9 🗀 Part II. O

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Health and Mental Hygiene. tem 27 is marked other than ther traumatic event, the N

permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tronce.

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the buria been signed by the should be detached cate has I funeral director, this within 24 hours after death.

To the Funeral Director: At completed filled in by the

Division of Vital Records, P.O. Box 68760

Physician/Medical Exam

Be Completed by

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Certificate:

Medical

25. Was

(Check only one

29b. Signature and title of certifie

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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3 🔲 Ectopic pr			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying ca	ause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
em physes	ma			1 Yes	2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of Death (Chec	k only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐R	VOutpatient 3 DO	A Other: 4 \(\sum \) Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	8b. Time of 28 injury M	c. Injury at work? 1 Yes 2 No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not 4 Homicide determined		e, farm, street, factory,	office	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled	ge, death occured at t	he time, date and place, a	nd due to the cause(s)	and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State Registrar of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nathaniel L. Roscoe, Sr. 20 ×2 Jänuary 档, Medical 12:35 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Director Hours (Month, Day, Year) 223-56-1263 67 1 X M 2 D F Jun. 20, 1944 Virginia 28a-f show 10a. State and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Seabrook 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9801 Stall Avenue 20706 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 12 Carpet Sales/Installer marked other Carpet Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ano...
of Health an...
* item 27 is marn...
* traumatic ev ပ္ Lewis Roscoe Lillie Walker 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby O. Roscoe/wife 9801 Stall Avenue, Seabrook, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth Page 1 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Control (Specify) 4 Donation -Crematory 1-21-2012 Baltimore, MD re of Funeral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Examir the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or injun and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 1 the attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 1 Yes 2 L 9 Unknown Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate Yes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ Other: 1 X Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No After 28d. Describe how injury occurred 1 Natural 5 Pending s after death. Accident
Suicide Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ithin 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) IVVI DKM

State Registrar 31. Date filed (Month, Day, Year)

JAN 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheverly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ida Mae Richards 01 2012 :18 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Care Waldorf Center Charles Waldorf Social Security Number 7. Age (In vrs. last birthday If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Maryland 03/01/1926 Director 214-24-0376 85 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2X No MD Prince George Brandywine è 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 17020 River Airport Road 20613 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No 0 Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes, Give White "natural" 3 ₺ Widowed 4 □ Divorced Should be mon.

In and Mental Hygiene.

27 Is marked other than "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Tucker Estelle Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 17020 River Airport Road, Brandywine, MD 20613 Linda Mersch / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Cedarville Church Cem 01/17/2012 Brandywine, Maryland 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fune al Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Cerebrovascular Disease Unknown disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Diabetes Mellitus and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical certificate be Box 68760 as the k IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months? Pregnant at time of death detached g Unknown g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Cardiovascular Disease 1 Yes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has b autopsy performed? Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated S. X. Certifying Nurse Prantioner: To the basis of my incominate data the time, data and place, and due to the cause(s) and manner stated (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) in cures all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009

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32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:00P M Alan Ramsay 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 513 Goldspire Circle Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 XM 2 □ F 212-54-3752 Director Yrs May 14, 1959 North Carolina 52 Usual Residence of Decede 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location Director notified 1 ☐ Yes 🏋 ☐ No Maryland Frederick Frederick 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 5 must be 23a Funeral 21703 USA 513 Gold Spire Circle items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 1. Marital Status Examiner Armed Forces?

1 Yes 2 No or. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 X Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Refinisher Furniture 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kendall Lathrop William Ramsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury or 27 Germantown, MD 20874 12824 Locbury Circle Apt. B, <u>Jessica Ramsay / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🏋 Cremation 3 🗆 Removal from State 1/19/2012 Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) Stauffer Funeral Home . Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 out the Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, those, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** 10An na Hosi Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events YEM CHEOME Mcollo Li St and Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical requires that the death certificate be Box 68760 the as attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death ed by the a Unknown g Unknown P.O. Part II. **Ot**he**r significant conditi**ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 No I or Attending Physician: after death. 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 \square Nursing Home 5 \nearrow Residence 6 \square Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurs Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

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BAUGHMANI love Sate 140

FREDERILL MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MENOCM

Year.

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no-110

32. R. gistrar's Signature

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		For State		State	of Ma	ırylan		artment o			lental H	ygier	ne .		
		Registrar	pr				Ce	ertificate d	t Dea	th		Reg. N	10.	12	02077
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and and		Usual Residence of De 10a. State 10	ecedent Ob. County		1	10c. City	, Town or L	ocation							0d. Inside City Limits
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ems ems	Funeral	11. Marital Status		12. Was De Armed F		ver in U.	S. 13	. Was Decedent	of Hispanic	Origin? (Specican, Puerto	ecify Yes or N	10-		- Americ	ean Indian,
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hour tural	pa pa			Year or	Dates:		16a Dec	edent's Usual Oc	cupation			16h	Kind of Bus	inoco/In	ductor
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filed within 72 hours after death with the Maryland Hygiene. uther than "natural"; or Items 23a or 28a-f show ont, the Medikal Examiner must be notified at	Completed	Elementary/Seconda	ary (0-12)	College	(1-4or 5- 2	+)	Te	acher				E1	lement	ary	School
e file al Hy d othe	Be	17. Father's Name (First	rst, Middle,	Last)					18. M	other's Name	e (First, Middi	le, Maid	en Surname	e)	
ould the Ment arked	ို	Musai]]	Etwari	<u>a</u>				
12 sh hand rism raum		19a. Informant's Name						ling Address (Str							Code)
1 and Healt em 2	-	Jean A. Da 20a. Method of Disposi		a/Daughte	r	120b. P		6 Devily			Potom Date		MD 20 Location - 0		own State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		· ·	Cremation	3 ☐ Removal from	m State			oosition (Name or ematory or other		8 8 1				•	
arthe ortan	Ш	21. Signature of Funer			1	Gat		Heaven (22. Name and Ad			/2012 Vol Fu				ig, MD
permit. Departr Imports any Inj.		Risa	n 7	Mª MUVII	in	MO12	1	0 E. Dee		De					m 20877
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Physician		Immediate Cause (Final disease or condition		•			ena1	Disease							Onset and Death 6 Years
/Medical		resulting in death)				consequ		Discuse							o icais
Examiner	L	Sequentially list condit	tions,	b	,										
pa #	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury b. Due to (or as a consequence of):													
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rtifical ng phy as th	Medi	IS SENALS.		-											
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Medica	23b. Was decedent pre		23c. if yes, o	utcome p	of pregna 2 □ Fetal		□Ectopic pregna	nev				23d. Date		•
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hat the	Phy	Part II. Other significa	nt conditi	ons contributing to	death bu	t not resu	ulting in the	underlying cause	niven in P	art I	23e Did	tohacc	o use contril	hute to t	he cause of death?
w requires that s been signed t should be deta	d by	Coronary					······g		3						pably 4 🕅 Unknown
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slcian: The law certificate has b irector, page 2 s	Completed		LDI II.	Lacton							aut per	opsy formed?	pr de	ior to co eath?	mpletion of cause of
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Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No		Hospital: 1] Inpatier	nt 2 🔲 I	ER/Outpatie	ent 3 DOA	Othor:		me 5□Re		6 □Othe	r (Specii	
ding Phys h. After this funeral dir		27. Manner of Death	5 ☐ Pendir	(8.80	e of Injur		28b. Time Injury	of 28c. I	njury at Vork?		28d. Describe				
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spital ours a neral filled		29a. Certifier 1	X Certifyli	ng Physician: To th	he best o	f mv knov	wledge, dea	ith occurred at th	e time, dat	e and place.	and due to th	e cause	(s) and man	ner as s	tated
To the Hospital or Attending Powithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	edical	(Check only 2 one)	☐ Medical	Examiner: On the	basis of anner stat	examinat	tion and/or i	nvestigation, in r	y opinion,	death occur	red at the time	e, date a	and place, a	nd due t	o the cause(s)
To th within To th comp	Me	29b. Signature and title	e of certifie	r				29c. Lic	ense numb	er		29d. [Date signed	(Month,	Day, Year)
10		Make	5-					D28	656			Ja	anuary	18.	2012
		30. Name and address	of person	who completed car	use of de	ath (Item	23a) (Type							;	
		Ravi Passi	L, MD	, 15245 S	hady	Gro	ve Ro	ad #130,	Rocl	kville	, MD 2	0850)		
Sta Registi		31. Date filed (Month, I	υay, Year) 9 Λ	2012	Hegistra	rs Signat	lure &	del.							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 19, 2012 Year Dominico Sixto Semeleer 10:15 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15005 Candover Court Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (*Month, Day, Year)* Aug. 5, 1947 **Funeral** 9. Birthplace (State or Foreign Aruba 1X M 2 | F Months Director 505-68-7546 64 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho Director 10d. Inside City Limits 1 Yes 2 X No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 15005 Candover Court 20906 Aruba Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. med Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify:West Indian 3 Divorced 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Higher Education Elementary/Seconday (0-12) College (1-4 or 5+) Library Technician Library System Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Epifanio Anselmo Semeleer Celestina Figaroa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Brenda L. Semeleer/Wife 15005 Candover Court, Silver Spring, MD 20906 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory 1 Burial 2 🖾 Cremation 3 🗆 Removal from State Jan 19 2012 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Congestive Heart Failure disease or condition years Medical resulting in death) Due to (or as a consequence of Examiner Diabetes Mellitus years Sequentially list conditions re to far as a consequence of if any leading to immedicause. Enter Underlying Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Dav 1 Yes 2 L 9 Unknown the Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2X N 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 K Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. n 24 hours after death.

e Funeral Director; Aipleted filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2, Certifying Nu irse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 29d. Date signed (Month. Day, Year) D38457 Jan. 19, 2012 30. Name and address of bers o completed cause of death (Item 23a) (Type, Print) Nakul Goyal MD3801 International Drive, #211, Silver Spring, MD 20906 31. Date filed (Month, Day, Year)

State

Registrar

1AN 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Edward Smith 2012 Medical January 9:45 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Center Crownsville Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) DISTRICT OF Columbia **Funeral** 8. Date of Birth (Month, Day, 1) 1 X M 2 □ F Months 578-46-2731 Davs Hours **Director** 76 Mar. Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits MD Anne Arundel Crownsville 1 Tes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 1454 Fairfield Loop 21032 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. by 1 X Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Specify: Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry alth and Mental Hygiene.
27 is marked other than r traumatic event, the Me than Elementary/Seconday (0-12) College (1-4 or 5+) 8 General Labor Bowling Alley Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 of Health and Ments William Edward Smith Gladys E. Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Coulson Road Crownsville, MD 21032 Department of Health ar Important: If item 27 is any injury or other trau Juanita Curtis / Niece Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 21, Enterprise Cemetery Ferndale, WA 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral H Severna Park, MD 21146 P.A. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. 23a. Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) curomo Medical Due to (or a a consequence of Examiner Sequentially list conditions, iner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed tran and resulting in death) Last Due to (or as a consequence of) burialigned by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 No g 🗌 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ▼ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending injury work? after death Accident Investigation M 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifyigg Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature 29d. Date signed (Month, Day, Year) D38958 rson who completed cause of death (Item 23a) (Type, Print) SW Plen Barne dic 208 Croin Mwy

Registrar DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

		1	For State Registrar	State of Ma	-	partment of F ertificate of L			giene _{Reg.} No	2011	2 102980	
Phys	ician	_	1. Decedent's Name (First, Middle, Las		:- C			2. Date of De Month	ath Day	v Year	3. Time of Death	
Me	edica mine	1	B. Ha. Facility Name (if not institution, give	lanche Mar: street and number)	ie Spears		Location of Death	01	1.3 4c.	3 2012 County of Deat		
LAG			St. Mary's	Hospital		Le	onardtown	n	St. Mary's			
Fune	4.0	5	5. Social Security Number 6. S		(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v Yearl	Co	thplace (State or Foreign untry)	
Direc		-	219-48-2086 Usual Residence of Decedent		73 Yrs			03/10/	1938	Mar	yland	
land show		בַּ [10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	
Mary 28a-1			Maryland St. Ma	iry's			ngton Par	k			1 Yes 2 No	
ith the 23a or	1	<u>a</u>	10e. Street and Number	ulip Way		10f. Zip Code	20653		10g. Cit	tizen of What Co		
eath v		Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	Was Decedent of H If Yes, specify Cuba	Ispanic Origin? (Spo	ecify Yes or No-	T	14. Race - Ame		
after d		2	1 X Never Married 2 Married	1 Yes 2 K N	No	1 ☐ Yes 2 🛣 No		riicari, etc.,	- 1	Black, White Specify: B	e, etc. Lack	
5-UU36 2 hours after "natural", o	1 1	Completed	3 Widowed 4 Divorced			cedent's Usual Occup			16b. K	and of Business		
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C Z1	It, uie	oo⊢	12			Homem				Own H	ome	
			17. Father's N ame (<i>First, Middle, Last)</i> Joseph A	lexander S	Spears		18. Mother's Nam			Fenwicl	κ	
Aarylance Should be file and Mental H is marked o		1	19a. Informant's Name/Relationship (7			ailing Address (Street	and Number or Run	al Route Numbe	er, City or	Town, State, Zi	p Code)	
y Mar nd 2 shou ealth and m 27 is n			Thomas Jay Spe	ars/ Son	134	7 Wilson R	oad Waldo	orf, Mar				
baltimore, Marylan permit. Page 1 and 2 should be fi Department of Health and Mental Importants if items 77 is marked any injury or other transmet.	5	1	20a. Method of Disposition 1 🏿 Burial 2 □ Cremation 3 □		cemetery, c	sposition (Name of crematory or other place	:e)	Date		ocation - City or		
ITIIT iit. Pa artmer ortant iniim	india.	-	4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Licen	-	St. John	1's Cathol:	es of Facility	9/2012		lywood,		
Dep de de de de de de de de de de de de de	onc		W. I DEL	ardiner)	Matting 41590 Fe	ley-Gardi enwick St	ner Fun reet, L	eral	Home,	P.A. MD 20650	
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4		je	Sequentially list conditions,	b. Due to (or as a	t Contequence of,	<u> </u>						
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fbU cate be executed physician and she burial-transit	!	<u>छ</u>	resulting in death) Last	Due to (or as a	consequence of):							
Division of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and compulsed filled in by the funeral director page 2 should be detached for use as the burial-transit		edical		d								
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GO death the att	3	SICI	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown		5 Other (specify)				Month	Day Year	
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DIVISION OF VITAL HECONTS, tal or Attending Physician: The law requires ts after death. al Director. After this certificate has been sig al one drin by the fineral director pane? should his		Completed	OND F	TAKE RE	ENTE	MSEALE		24a. Was		prior to	utopsy findings available completion of cause of	
The land	hage	5						1 🗆 Yes	ormed?	death?	s 2 🗆 N o	
Ital sician: certifi	lologi l	ň	25. Was case referred to medical examiner?	Hospital:		Oth	er:			-		
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or Att or Att after d Directe in by 4	6	Certificate:	4 Homicide determined			street, factory, office		28f. Location (City or To			ural Route Number,	
Spital hours in neral l		Medical	29a. Certifier 1 Certifying Phy	ysician: To the best of	my knowledge, dea	ath occured at the time	e, date and place, a	nd due to the ca	ause(s) ai	nd manner as st	ated.	
the Ho nin 24 I the Fu	biological in the second in th		only one) 3 Certifying Nui	niner: On the basis of ex rse Practioner: To the l							cause(s) and manner stated. s stated.	
5 tight	3		29b. Signature and title of certifier	· ·	M	29c. Licens	e number	,		te signed (Mont		
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Tvr	pe, Print)) 60 96					
Deme			ILA JBINDER	S. GILL	SIN	ANY'S HO	SM7AL	LEON 18	40 1	ON N. 11	1) 20636	
	State istra		31. Date filed (Month, Day, Year) JAN 1 8 2	32. Kegistra	ar's Signature	ANYS MC						

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death anuar Physician/ raller CLM 2 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Contex La 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗗 F Hours Yrs **Director** Arch Jan Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sl 1 Yes 2 X No Leonardtown Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r Funeral 20650 USA 20938 Camp Cosoma Road er than "natural", or items the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates Specify: White 3 🔯 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm Legal Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ida Pillsbury Benjamin Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20637 6822 Buckeye Drive Hughesville, MD Maria Hoover/ Daughter injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of I Important: If its any injury or of once. cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State St.Francis Xavier Catholic 4 ☐ Donation 5 ☐ Other (Specify) 01/30/2012 Compton, Maryland Signature of Funeral Service Lice Name and Address of Facility Mattingley-Gardiner Funeral Home, 41590 Fenwick Street Leonardtown, MDA 20650 /ard 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or Examir physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (g Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending pd be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 015 24a. Was an autopsy performed Yes 2 has eral Director: After this certificate filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death of cured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or invest Certifying Nurse Practioner: To the best of my knowledge, gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated eath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of 1

0

person who completed cause of death (Item 23a) (Type, Print)

32. Regist

JANSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pau1 Arthur 2012 10:10 PM Svenson January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Hospice House of St. Mary's Callaway 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Hours Mir (Month, Day, Year) 04/26/192 Months Yrs Director Nebraska 508-12-5839 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD St. Mary's Lexington Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or Funeral 21548 Searfoss Court 20653 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 14. Race - American Indian, Armed Forces Black White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Maximonole." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Svenson Christine Sorensen Sven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Brinsfield/Daughter 21548 Searfoss Court Lexington Park, MD 20653 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 4 Doppion 5 Other (Specify) Brinsfield-Echols 01/23/2012 Charlotte Hall, MD d furbral kervice i cense Brinsfield Funeral Home, P.A. Road Leonardtown, Maryland 20650 Margaret H. Hicks M01637 22955 Hollywood Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day Year 5 Other (specify) Month Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 X page 2 s After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural injury 5 Pending work? of Funeral Director: A oleted filled in by the funeral process. 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier mpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

5) Rme State

within 2

30. Name and address of per on who completed cause of death (Item 23a) (Type, Print)

Jennifer Schmidt, 40900 Merchants Lane Suite205 Leonardtown, Maryland20650 M.D.

H005575

29d. Date signed (Month, Day, Year)

3 🗆 29b. Signature and title of certif

only one)

Registrar

12-00808

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eslie Ann Sternei	1	State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		Reg. No. 20	12 0298
Physician	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De Month	ath Day Year	3. Time of Death
Aedical Examine		Leslie Ann Sterner	January 2	27, 2012	1944 hrs
	1	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital Baltimore		4c. County of D	eatn
		Ot. Agrico i lospitar	In Date of B	irth(MM/DD/YYYY) 9	Rirthplace (State or
Funeral	- 1	Months Days Hours Min.	-	F	oreign
Director		212-08-8179 1 M 2 F 37 Yrs.	Nov 2	6, 1974	Country) MD
A	-	Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County			10d. Inside City Limits
. ★ ♣0y					1 Yes 2 No
Aaryland 28a-f show 1 at ooce	ខ្ញុំ	MD Baltimore Baltimore 10e, Street and Number 10f. Zip Code		10g. Citizen of What	Country?
th the Maryland 23a or 28a-f sho notified at occe.	DIFECTOR	150, 0100, d.i.e 11411257			
th the notifi		510 Kent Avenue 21228 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	secify Yes or N	United 14 Race - A	States merican Indian, Black,
tems at be		1 V Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, e	
er dez		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: T	White
irs aft	⋛├	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		16b. Kind of Busin	
2 hou	<u>ğ</u> -	Elementary/Secondary (0-12) College (1-4 or 5+)	red)		
36 thin 7 than than edica		12 Emissions Tester		State of	f Maryland
5-0036 lead within 72 hours after lead within 72 hours after other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle	Maiden Surname)	· - ·
	9			<u>Hambrick</u>	
21215-0036 hould be filed within 72 mand Mental Hygiene. is marked other than stie event, the Medical	_ا •	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address)			
MD d 2 sho lth and n 27 is		2000) 0020 102000-77	imore,	Maryland	21228
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		3	
Pages ent of	1	1 X Burial 2 Cremation 3 Removal from State Good Shepherd Cemetery 2/1			city, MD
Baltimore, pernit. Pages l at Department of Hei Important: If ite injury or other tr	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tax 1	y H. W	itzke's Fa	emily F.H. Inc
E.F.S.		Juanta Refronço 4112 Old Columbia I	<u>Pike El</u>	<u>licott Cit</u>	y, MD 21043
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
nviedicar Examiner	İ	Immediate Cause (Final disease a. Acute Staphylococcal Necrotizing Pneu	monia		Death
Zammer	1	or condition resulting in death) Due to (or as a consequence of):			
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
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Box 68760, c death certificate but attending physical for use as the but	뒮	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant in the	ancy	Month	Day Year
leath ce attend for use	2	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown		I	
be de f	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
P.O. E es that the d igned by the	≦	Tarin Salar Significant Control of the Control of t	1 🗆 Y	es 2 🗹 No 3	Probably 4 Unknown
quires en sign	Completed		24a, Wa		re autopsy findings available
aw requi	흷		per	formed? dea	
Rec The l	팃			2 No 1 V	Yes 2 No
Vital Recysiciae: The his certificate director, page	8	25. Was case referred to medical examiner?		Residence 6	Other
hysic I dir	ᆰ	1 Yes 2 No Inpatient 2 FR/Outpatient 3 DOA 4 Nursi		e how injury occurred	other.
ding Phy	崩	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No	20di Doodii	o now injury documen	
Sior	讀	Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location	(Street and Number	or Rural Route Number, City
Division of Vital Records, pital or Atteoding Physiciae: The law require ours after death. eral Director: After this certificate has been sifilled in by the fineral director, page 2 should be.	Certification:	Suicide 6 Could not be	or Town		or real results real bor, only
bou fill		4 Homicide (Specify) 29a. Certifier Check only (Check only Check on Check only Check only Check on	due to the co	use(s) and manner of	s stated
To the Hospit within 24 hour To the Funers completely fill	<u>8</u>	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, da	te and place, and due	to the cause(s)
Tot with Tot	Medical	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
	-	O.C.M.E.		January 28,	
_		(cell Villa sielle			
3		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 21	223	
Sta	te.	22 Phojetrario Signaturo			
Registr	ar	31. Date filed (Month Day, Year) 2012 Segistrar's Signature.			

12-00520

Robert Leroy Scott, 3rd

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	State of Maryland	Department of He	ealth and Mental Hygiene	

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Physici		Decedent's Name (First, Middle,L.	ast)					Date of Death		3. Time of Death
Medical Exam	iner	Robert Leroy So			1		J	anuary 18	, 2012	1635 hrs
*		4a. Facility Name (if not institution, g 3277 Queens Town Drive			-	Town, or Location	of Death		4c. County of D	
Funeral				rs. last birthd			er 24Hrs. 8.	Date of Birth		. Birthplace (State or
Director		216–33–2836	™ ₂ F 20		Yrs. Mont		Min	06/11/) Fe	oreign Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limits
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urylan Sa-f si	용	10e. Street and Number		2		p Code		10	g. Citizen of What	Country?
15-0036 filed within 72 hours after death with the Maryland Hygiene. of other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at ooce	I Director	4603 Burlingto				20781			U.S.A	
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5-0036 led within 72 hor Hygiene. other than "nai	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	dur	ing most of wo	orking life. DO NOT	use retired)			
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Robert Leroy 19a. Informant's Name/Relationship	<u>'</u>	10h A	Anilina Addana		nda Sv		0" T	7.015
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늘 등 등 점 점 의		1 Burial 2 Cremation 3	_	crematory Ft. Li	or other place ncoln (01/27	7/12	Brentwoo	d,Maryland
Baltimo permit. Page Department of Important:	1	4 Donation 5 Other Special 21. Signature of Funeral Service Lice	y:							
Den Den in in in in in in in in in in in in in	- 1	Jany N	Crall	29	Hen: 4925 Bi	ry S. Was urroughs	hingto AveN	on & So J.E. Wa	ons Co.,I ashinaton	nc. ,D.C.20019
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Medical Examiner		Immediate Cause (Final disease								Death
Examiner	- 1	or condition resulting in death)	Due to (or as a consequen	ce of):						
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	盲	cause. Enter Underlying Cause	o							
red nsit	Examiner	events resulting in death) Last	Due to (or as a consequent	ce of):						
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760, cate be ex physician he burial	Medical	IF FEMALE:	23c, If yes, outcome of p				·		23d. Date of deli	verv
		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death	3 Ectopic	c pregnancy		Month	Day Year
Box 687 e death certific the attending p	sici	1 Yes 2 No 9 Unknow	4 Pregnant at time o	of death 5	Other (Spe	ecify)			İ	
D. Boy t the death by the att	Physician	Part II. Other significant conditions		not resulting in	the underlyin	g cause given in Pa	art I.	23e. Did tob	acco use contribute	to the cause of death?
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tal Re- inn: The certificate		25. Was case referred to medical				26.Place of Death	(Check only	1 Yes 2	No1 ✓	Yes 2 No
Vita ysicisi his cer direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpa	atient 3 [OOA Other			esidence 6 🗸 O	ther: Scene
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ion tendii tor: /	흝	1 Natural 5 Pending 2 X Accident Investiga	fd 1_19_12	fd 0	4:30 pm	1 Yes 2 🛣	No Su	bject	drowned :	in creek
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raper death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of Injury - A			y, office building, et	c. 28f.	Location (Stror Town, Sta	reet and Number of the 3277 Que	Rural Route Number, City
Dapita hours tille		4 Homicide	(opcomy) 10	und:Cr						
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the state of the	Medical	(Check only Certifying Physi	cian: To the best of my know er: On the basis of examination and manner stated.							
HAHS	ž	29b. Signature and title of certifier		1	29	c. License number			29d. Date signed (Month, Day, Year)
		11/1/	1	N Y		O.C.M.E.			January 19, 2	012
2		30. Name and address of person who Russell Alexander MD.	completed cause of death (Assistant Medical Ex	-	900 W. Ba	Itimore Street,	Baltimore	, MD 212	23	
		31. Date filed (Month, Day, Year)	32. Registrar's Sig		0				OLIF	
Regis	ırar	JAN 2 7 2012	Beer S. A	back	15			C	OME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January Town, or Location of Death

Physician /Medical Examiner

Funeral Director

or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at "natural" than " Health and Mental Hygiene.

Maryland 27245-0036

Baltimoré,

Box 68760.

P.O.

of Vital Records,

Division

1 and 2 should be

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any Injury or other trau

Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria been signed by the should be detached page 2 s has this

completely filled in by the funeral director, s after death. 24 hours a within 2 the 2

DOROTHY ELLEN STEWART 4c. County of Death Facility Name (If not institution, give street and number ENTER LATA HARLES DICAL If Under 24 Hrs. 5. Social Security Number 1 Year 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours Min 211-26-2206 PA. 8-31-1934 77 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES 1 □Yes 2 No WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 334 TUMBLEWEED PLACE Funeral 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify þ Specify: WHITE 3 ☐ Widowed 4 ➡ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HOSPITALS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DONALD HAROLD BRICKLEY ပ္ RUTH EVA SHUTTLEWORTH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD W. STEWART-SON 5200 MARBURY RUN RD. MARBURY, MD. 20658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MF: METROPOLI TAN CREMATORY 2-1-12 ALEX VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 29646

Do not enter the mode of dying, such as cardiac of respiratory arrest, N 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one of the on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or Due to (o Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 🗆 Unknown ntributing to death but not resulting in the underlying cause given in Pert I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Nepatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deeth Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Name and address of person Inla 1. 31. Date filed (Month, Day, Year) FEB 0 3 2012 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh / g925 3-22-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 36 Glenys L. Symonds Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown, MD Meritus Medical Center 7. Age (In yrs. last birthday) 78 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 010-26-5890 1 🗆 M 2 🛂 F **Director** 10/4/1933 Malden, MA 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 14615 Pennersville Road, Cascade, MD 21719 1 Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 21719 USA 14615 Pennersville Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ı ∟ Yes 2 No If Yes, Give Year or Dates. Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify. white 3 → Widowed 4 □ Divorced Specify "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the own home 11 homemaker Be 17. Father's Name (First, Middle, Last) Joseph G. Savary 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
raumatic ever ည Enid Field 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11913 Commanche Drive, Smithsburg, MD 21783 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Dan W. Symonds son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 1/28/2012 Cascade, MD 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PA 17268 21. Signature of Funeral Service Licenses kur Denne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MetaStatic Physician/ monThe Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any sacing to immediate cause. Enter Underlying Due to for as a consequence of Physician/Medical Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burlal-tran Due to (or as a consequence of) P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant
9 Unknown Month Dav Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertenscon Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed Dialetise mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has it page 2 s After this certificate 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident 24 hours after death Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ______Gertifying human Predictioner: To this basis of my incomedge, overhood in the first cause of the new part of th (Check within 2 To the I only and 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 044996 ausgrof death (Item 23a) (Type, Print) 20311 Cosppans Rd Roomston MD 21713 Ialik

-X

DHMH 17 Rev 06-2011

State Registrar egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ŽÖ12 2:54 AM January Josephine Lucy Teavs Medical 4a. Facility Name (if not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death **Examiner** Washington 1835 Abbey Lane Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🛛 F Months Min 10720/1939 New York Director 063-32-5303 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 1835 Abbey Lane Apt. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 th Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Lucy Marie Magnet Michael Cantineri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 11230 Hollywood Road, Hagerstown, MD 21740 Robert M. Teays / 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State ŏ ò 1 X Burial 2 Cremation 3 Removal from State 01/26/2012 Hagerstown, MD injury 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 North Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician Physician/Medical as been signed by the attending p 2 should be detached for use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed Yes 2 death? 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 3 No 1 Yes 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury within 24 hours after death. To the Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D35497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Pagistrar's Signature

1122 OPALCT. HAGERSTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Frances Talley January 13, 2012 11:23p4 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Holy Cross Hospital Montgo mery Silver Spring Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Days 578-58-2373 Months Year, Director 82 Washington DC 1929 June 14, Usual Residence of Decedent 28a-f shov 10a, State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington N/A DC 1 yes 2 No 10f. Zip Code 20017 10e. Street and Number ò 10g. Citizen of What Country? 737 Crittenden Street, NE 23a Funeral United States items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. **African** ò þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural", 3 Midowed 4 ☐ Divorced Specify: A merican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Radiology Technician and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Be Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) ၉ Halley Agnew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Loft Way, Silver Spring, Maryland 20904 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen Miller Davis / daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/17/2012 1 Burial 2 X Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 22. Name and Address of Facility McGuire Funeral Service, 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Lung Cancer Sequentially list conditions cause. Enter Underlying Exami Chronic Obstructive Pulmonary Disease 3 Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death the Unknown 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 1 ☐ Yes 2 🛣 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔼 No 1 Tes မ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury n 24 hours after death.

e Funeral Director; Ai leted filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D65305 16,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nabila Khan 1500 Forest Glen Road, Silver Spring, Maryland 20910

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1	For State Registrar	State of Marylan		artment of H tificate of D			giene Reg. No. 20	2 02989			
	Physicia		1. Decedent's Name (First, Middle, Last) Charles Randolph	Thompson		Month	2. Date of Death Month January 19, 2012 3. Time of Death 11:20 a _M						
, rete	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)	o dilida i	4c. County of Death							
-	- 2		21290 Mayfaire La: 5. Social Security Number 6. Sex		ast hirthday)	Lexingt If Under 1 Year	on Park If Under 24 Hrs.	8. Date of Birt		St. Mary's 9. Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 219-48-3285 6. Sex 1 X M 2 F 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 6. Sex 9. Birthplace (State or Fore Country) 1 X M 2 F 6. Sex 1 Months Days Hours Min. 1 Months Da										
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
		Director	MD St. Mary's Lexington Park							1 ☐ Yes 2 🔀 No Citizen of What Country?			
			10e. Street and Number 21290 Mayfaire Lan	e. Unit 101		10f. Zip Code 20653		I	United St				
		14-1	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, White, etc.			
920		sq ps	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒No If Yes, Give Year or Dates.	Yes, Give 1		Specify:		Specify:	Specify: White			
21215-0036	72 hour r "natur edical	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa	ation uring most of worki	'ng	16b. Kind of Busin	Kind of Business Industry			
212	within 7 giene. er thar the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DO NOT use retired) Stock Clerk			Grocery	ocery			
Maryland	Page 1 and 2 should be filed v ment of Health and Mental Hyg ant: If item 27 is marked othe ury or other traumatic event,	To Be											
aryl			19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Numbe	r, City or Town, State	e, Zip Code)			
e, S			James Coleman 20a. Method of Disposition	(Cousin)		Box 345,		, Maryla	and 20664				
Baltimore,			1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crer insfiel	natory or other place Ld-Echols	01/2	4/2012	Charlott	e Hall, MD			
Balti	permit. Page 1 Department of Important: If it any injury or c		21. Signature of Funeral Service License Danielle Ward	Danielli W						Home, P.A. MD 20650			
Medical Examiner		iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of nach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, list any leading to himself at a consequence of: Due to for as a consequence of:										
09.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	C									
. Box 687		Physician/Me	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1							23d, Date of delivery Month Day Year			
ds, P.O.		Completed by PI	Part II. Other significant conditions con	Yes 2 ☐ No 3	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown								
Division of Vital Records,	e law re e has be ge 2 sho	omple	24a. Was an autopsy findings available prior to completion of cause or death? 1 Yes 2 No 1 Yes 2 No										
al R	sician: The law recertificate has the lirector, page 2 s	Be Co								ZINOI TE TES ZE NO			
f Vit	Physic this ce	은	1 Yes 2 No		e 5 Residence 6 Other (Specify) d. Vescribe how injury occurred								
ou o	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director, After this certificate ha completed filled in by the funeral director, page	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury M			work? M 1 Yes 2 No						
ivisi		Certi	3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ц		Medical Certificate:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the within To the comp	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	14-0	,		112			
William D. Boyd, II M.D. 25365 Point Lookout Road, Leonardtown, MD 20650									20650				
	Sta Registi		JAN 2 4 2		B. A.	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #5 Per FH G924 2/13/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 19 2012 January 6:00 AM Vincent Lee Thrasher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall Social Security 147298 If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days 0172771923 497-18-0468 88 Missouri **Director** Usual Residence of Decedent 28a-f show 10a. State , or items 23a or 28a-f sho iminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland | Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4705 St. Leonard Road 20685 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates] 943—1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or than "natural", or iter the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ဂ္ Roy Lee Thrasher Mary Anna Clickner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 3629 5th Street, North Beach, Orval Lee Thrasher / Maryland 20714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial 01/27/2012 Dunkirk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Rausch Funeral Home, PA 4405 Broomes Island Road, Port Republic, M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ stage Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, reading to inmediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Embolism, Comonary heart disease 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Lung disease, Chronic kidney disease 24a. Was an Interstitial autopsy performed? 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 2 🗌 Accident 3 🔲 Suicide 4 🗎 Homicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thibins: D0064-32A Jan 19, 2012 dru 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thibin Santha, 100 Hospital Rd, Prince Frederic, MD120678

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar Signature

12-00193 Mike Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death RegistrarAmeno#1_PerMFO1-25-12PGCcr Reg. No. 2. Date of Death Physician/ 3. Time of Death **Medical Examiner** Mike Thomas Michael Jerome Thomas 2230 hrs January 6, 2012 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 577–76–3425 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 55 1 X M countMaryland 2 F 06/21/1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, th<u>e Medical Examiner must be notified at once.</u> Md. Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Oxon Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6556 Bock Terrace 20745 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes 3 Widowed Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Black Specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 8th Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren W. Thomas, Sr. Agnes Marguerite Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle D. Thomas/Daughter 1214 Boones Hill Rd. # 3, Capitol Hgts., Md. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Gate of Heaven Cem. 01/18/12 Donation 5 Other Specify. Silver Spring, Md. 22 Negrand Address Washington & Sons Co., Inc. injury 21. Signature of Funeral Service Licenses luce 1 at 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part If Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and red for use as the burial - transit Physician/Medical UNPENDED AMENDED of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 V No 9 Unknown Unknown icate has been signed by the page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? this certificate 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗸 Inpatient 2 Other | Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 1 🗸 Yes င္ 2 No funeral 28a. Date of Injury (Month Day,Year) Jan 6, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Pedestrian struck by a motor vehicle ___ Natural 1 0703 hrs Division 5 Pending 1 Yes 2 V No hours after death. within 24 hours after death To the Funeral Director: the 2 🗹 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 6228 Oxon Hill Road, Oxon Hill, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 7, 2012 Surrul 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-00373 State of Maryland / Department of Health and Mental Hygiene Brian Keith Tann 2012 02992 Certificate of Death 1- For State Reg. No. Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day 2322 hrs January 12, 2012 Medical Examiner Brian Keith Tann c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral country) Months Days Hours SC Director August 27,1968 43 218-92-0329 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 X Yes 2 No , or items 23a nr 28a-f show MD Prince George's Landover permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury nr ather traumatic event, the Medical Examiner wast be neithed at outer. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 7733 Bender Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married **Black** 2 X No 1 Yes 1 Yes 2 No specify: Specify f Yes. Give Yea 4 Divorced 3 Widowed 2 or Date: 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Coilege (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 <u>Private</u> Handyman 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Billie Ann Griffin Curtis C. Tann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 20785 7733 Bender Road, Landover, Billie Ann Tann/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harmony 1-20-2012 Landover, 4 Donation 5 Other Specify Memoria Pope Funeral Homes, P.A. 22. Name and Address of Facility 21. Signature of Funeral Servi 5538 Marlboro Pike, Forestville, MD 20747 Plant I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** een Onset and Death Medical a. Gunshot Wounds (2) to Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury trial initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran ician/Medical AMENDED UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Day Year 3b. Was decedent pregnant in the 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Physic Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown <u>\$</u> Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be of Vital Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Subject shot Certification: FOUND: 1 Yes 2 ✔ No Natural Division Pending 2224 hrs Jan 12, 2012 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 7736 Bender Road, Palmer Park, MD (Specify) At residence 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier

Registra

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

9 2012

O.C.M.E

OCME

January 13, 2012

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Valdin $201\tilde{2}$ Vermillion Medical January 5:16 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2<u>3411 Brown Road</u> Hollywood Mary' 8. Date of Birth (Month, Day, Year) 01/24/1927 Birthplace (State or Foreign Country) **Funeral** Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days 1 🔀 M 2 🗆 F Hours **Director** 214-30-0219 84 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 X No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 23411 Brown Road 20636 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. 0 \$ 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: "natural" Completed 3 XWidowed 4 ☐ Divorced Year or Dates White or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Fendall J. Vermillion Blanche Irene Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Cheryl Burdette/Daughter 24985 Jones Road, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 01/27/2012 Silver Spring, MD Heaven Cem 22. Name and Address of Facility Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. Dani<u>elle Ward</u> M01403 2955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying and I-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? hours after death. neral Director; Aff d filled in by the fur 1 Yes Accident Investigation М 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

(12) PUMP

Registrar

DHMH 17 Rev 7/2009

30. Name and address

Jennifer Schmidt,

JAN 2 6 2012

40900 Merchants Lane, Leonardtown, MD

rson who completed cause of death (Item 23a) (Type, Print)

D.O.

12-00551 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles William Wiles State of Maryland / Department of Health and Mental Hygiene 2012 02994 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Charles William Wiles Month Medical Examiner 2154 hrs January 19, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number 220 – 42 – 5839 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign MD Country) Directo Months Days Hours 12-30-1942 1 XM 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Clear Spring 10d. Inside City Limits MD Washington 1 Yes 2 XNo rarmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Usparment of Health and Mental Hygiene.

Lieparment of Health and Mental Hygiene.

Liepartant: If item 27 is marked other than "natural", or items 23s or 23s-4 she right or other traumatic event, the Medical Expansion must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12614 Independence Road 21722 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes white 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) rubber industry splitter operator 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Scott Wiles 8 Julia Irene Johnson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12614 Independence Rd. Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) P Rose M. Wiles wife 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition -25°-2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Cem. Hagerstown, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc e disease, or o implications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory frest, shoot or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Sa has been signed by the attending physician as 2 should be detached for use as the burnal UNPENDED AMENDED Physician/Medi Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform<u>ed</u> death? page this certificate Yes 2 ✔ No 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural neral Director: __ Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 [Suicide Could not be or Town, State) To the Hospital of within 24 hours at To the Funeral D determined Homicide completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 20, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day Year)

ORI

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day NO SI 7:45 AM JUNG ES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ins W 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 1 🗆 M 2 💢 F 216-14-5034 88 9/22/1923 Maryland Usual Residence of Deced show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Washington Hagerstown 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Completed by Funeral 10823 Allen Avenue 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 ₩Widowed 4 □ Divorced Year or Dates. White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education <u>Secretary</u> $\mathbf{B}^{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Leatherman Stouffer Lilly Viginia Lankford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Hoover/Granddaughter 14120 Newcomer Road, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/24/2012 Hagerstown, Maryland ice License 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signatu of Funeral So 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) 10000 Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant
9 Unknown Pregnant at time of death Other (specify) 9 🔲 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy perform death? 2 X No I ☐ Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) OSS 15 Cd 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No iniury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

only one 29b. Signature and title of cont

29d. Date signed (Month, Day, Year,

M& 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Marylan		artment <i>rtificate</i>			Mental H	ygien Reg. N	711	12	02996
	Physici	an	Decedent's Name (First, Middle, Last) 2. Date of Death Month									D	Day Year 3. Time of Death		
-4	/Medic	cal		Aloysius				4h City To	we or loca	ation of Death	Januar		5, 20 c. County		5:59 p.m.
	Examir	ner	,	y's Hospi		inber)			ardto		ı		St. M		s
	Funeral		5. Social Security	Number 6.	Sex	7. Age (In yrs.	last birthday	If Under 1	Year If U	Inder 24 Hrs.	8. Date of B	irth	r)		lace (State or Foreign
	Director		214-28-4	+019	1 🛣 M 2 🗆 F	79	Yrs.	Yrs.			03/21/	1932	<u> </u>	Mary]	Land
	land ow		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or L	ocation						1	0d. Inside City Limits
	Mary a-f sh	Şç	MD St. Mary's Leonardtown								1 □Yes 2 🙀 No				
	or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co								Vhat Coun	itry?			
	ath wi	ral	40204 Follycove Lane 20650 United								l States				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be rediffed at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:			S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify:						14. Race - American Indian, Black, White, etc. Specify: White			
5-0	72 ho	Completed	(Specify only highest grade completed) (Give kind of work done during most of working						16b.	6b. Kind of Business/Industry					
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Baltimore,	ages int of h			Cremation 3		State	cemetery, cre	osition (Name matory or oth	er place)	01/					
altin	nit. Pa artme ortant Injury e.		4 Donation 5 Other (Specify) St. Francis Xavier 01/20/2012 Leonardtown, MD 21. Signature of Funeral Service Licensee 1/20/2012 Leonardtown, P.A.												
ä	permi Depar Impor any Ir		Danielle Ward M01403 22955 Hollywood Road, Leonardtown, MD 20650												
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
	Physician /Medical		disease or condition resulting in death) a. Fatal Cardiac Pyorhy-thmia												
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Spro	equire sen si	ted									1 🗆	Yes	2 No	3 ☐ Prob	bably 4 Unknown
JOS6 al Record	n: he law r ficate has of r, pege 2 sh	Completed									per 1 □ Yes	topsy formed? 2 XI	,	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Vital	Physician: this certific	o Be	25. Was case reference examiner?	No medical	Hospital:	Inpatient 2	ER/Outpatie	ent 3 DOA			ath <i>(Check only</i> Home 5 ☐ Re		6 🗀 Oth	or (Cnasi	6.0
0 0	ng Phy ter thi	n: T	27. Manner of Dea	ath 5 Pending	28a. Date		28b. Time Injury		c. Injury at Work?	Transing i	28d. Describ				<i>y)</i>
In Sion	Attending r death. ector: Afte oy the fune	catic	2 ☐ Accident	investigation 6 □ Could not	on be			М	1 🗆 Yes	2 No					
1Kins Division	tal or At s after d al Direct ed in by	Certification; To	4 ☐ Homicide	determine	d 28e. Place build	e of Injury - At h ing, etc. <i>(Speci</i>	nome, farm, s ify)	treet, factory,	office		28f. Location City or T			er or Rura	al Route Number,
3	To the Hospital or Attending Physician: "he I within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 death occurred at the time, date and place, and due to the cause(s) and manner stated.												
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C) Rme		30. Name and add	dress of person who	01	se of death (Ite	m 23a) (Type	, Print)		/	new too		1	1 2	0650
9		ate	31. Date filed (Mo	nth, Day, Year)	32. F	Recistrar's Sign	ature	X 3?	7 /	60	1400	1	MI	1 2	0000
	Regist			JAN 1	9 2012	Clava	B.	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Physician/ Rachel Britt Webb 4:45 PMM January 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Burnett-Calvert Hospice House Prince Frederick 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Nov 9, 1941 Days Hours 1 🗆 M 2 💢 F North Carolina 70 246-66-1359 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any joiny or other traumatic event, the Medical Examiner mantal. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Dunkirk 1 Yes 2 XXNo Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20754 USA 3501 King Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. White If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ John Howard Woodard, Sr. Catherine Britt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Webb - Husband Dunkirk, MD 3501 King Drive, Date 20 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Clinton, Maryland Lee Funeral Home Calvert, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License 8200 Jennifer Lane, Owings, MD 20736 F@gldr Amandan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Dualto (or as a consequence of any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 3 Probably 4 Dunknown 2**** No Completed cate has been sig page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 2 🗌 No 1 Yes certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be HOSPICE examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this LOUSE funeral 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Accident injury 5 Pending 2 🗆 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral D

completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check only one

30. Name and address

Saymon 31. Date filed (Month. Day, Year ted cause of death (Item 23a) (Type, Print)

ME

32: Registrar's Signature

no comp

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

Prince Fred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 11:50 a.Mn. 2012 Allen Young Timothy January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Hospice House of St. Mary's Callaway Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/06/196 Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 🕅 M 2 🗆 F Director 51 220-78-1438 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 1 Tes 2 No St. Mary's Leonardtown Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral items 23a United States 20650 25606 Loveville Road · death v . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 hours after 1 Yes 2X No Specify Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Farmer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ပ Gertrude E. Armstrong James Edward Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20650 25606 Loveville Road, Leonardtown, MD Gertrude E. Young/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart Cemetery 01/28/2012 Bushwood, Maryland Signature of Funeral Service Licensee

Scantivas C

Kathleen Santivasci M008 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00872 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the shock, or heart failure. List only one cause on yethine. de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) physiciar Physician/Medical certificate be Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death Other (specify) the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident Natural 5 🔲 Pending 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2) pme State Registrar

within 2 To the

29a. Certifier

only one 29b. Signature and title

30. Name and address

Jennifer Schmidt, D.O. 31. Date filed (Month, Day, Year)

40900 Merchants Lane, Leonardtown, Registrar's Signatu

person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Date signed (Month, Day, Year)

20650

MD

3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0412M Douar Edward Black ZIMMERMAN, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington <u>Hagers</u>town 24 Hrs. Min. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Country Director 218-34-3465 1 🕅 M 2 🗆 F 74 Nov. 21 1937 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland Director notified 1 Yes 2 No Maryland Washington Hagerstown 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō ms 23a oi must be Funeral 17435 Amber Drive 21740 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes. Give "natural", or iten edical Examiner r Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1955-63 1 ☐ Yes 2 👿 No Specify: Specify: 3 Widowed 4 Divorced White Completed er than "natur , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) <u>Postal Service</u> <u>Driver</u> Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Black Zimmerman, Sr. Helen Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7435 Amber Drive, Hagerstown, Maryland 21740 JoAnne Zimmerman - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/24/2012 Williamposrt, Maryland Greenlawn Mem. Park 21. Signatur - For ral Service License 22. Name and Address of Facility Minnich Funeral Home Ε. Wilson Blvd. Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ply ician AUT disease or condition Medical resulting in death) Examiner Securifielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an d15858 perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 DINO Other: 1 Yes ပု 1 Management 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Could not be after death Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

1W-15+

JAN 2 3 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5, per fh. g924 2-9-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Ann Delores Alston Year 7:05 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 810 Woodmont Ct. Harford Joppa Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** Months Days Hours Min 9 13 1 1936 75 **Director** 217-30-5063 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with : 810 Woodmont Ct. 21085 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Mexicology. Was Deceus.
Armed Forces?
Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð 1 Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Franklin Sq. Hosp. 12th 4yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Herbert Alston, Helen Webster 19a. Informant's Name/Relationship (Type, Print)
Donna Williams—Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Woodmont Ct. Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 2/4/2012 Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final STROKE Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ATRIAL FIBRILATION MAY /2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine MORBID OBESITY Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUPERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 213/12 0051349 30. Name and address of person who completed cause of death (Item) 23a) (Type, Print) Fran Veronica Deza 91 01 Baltimore Mil lih 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009